NOVEMBER, 193

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CONTENTS

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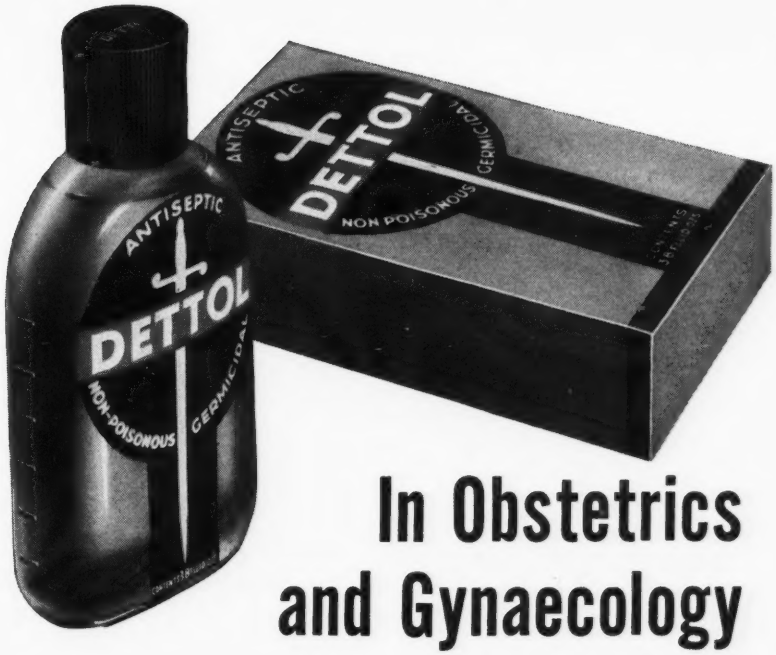

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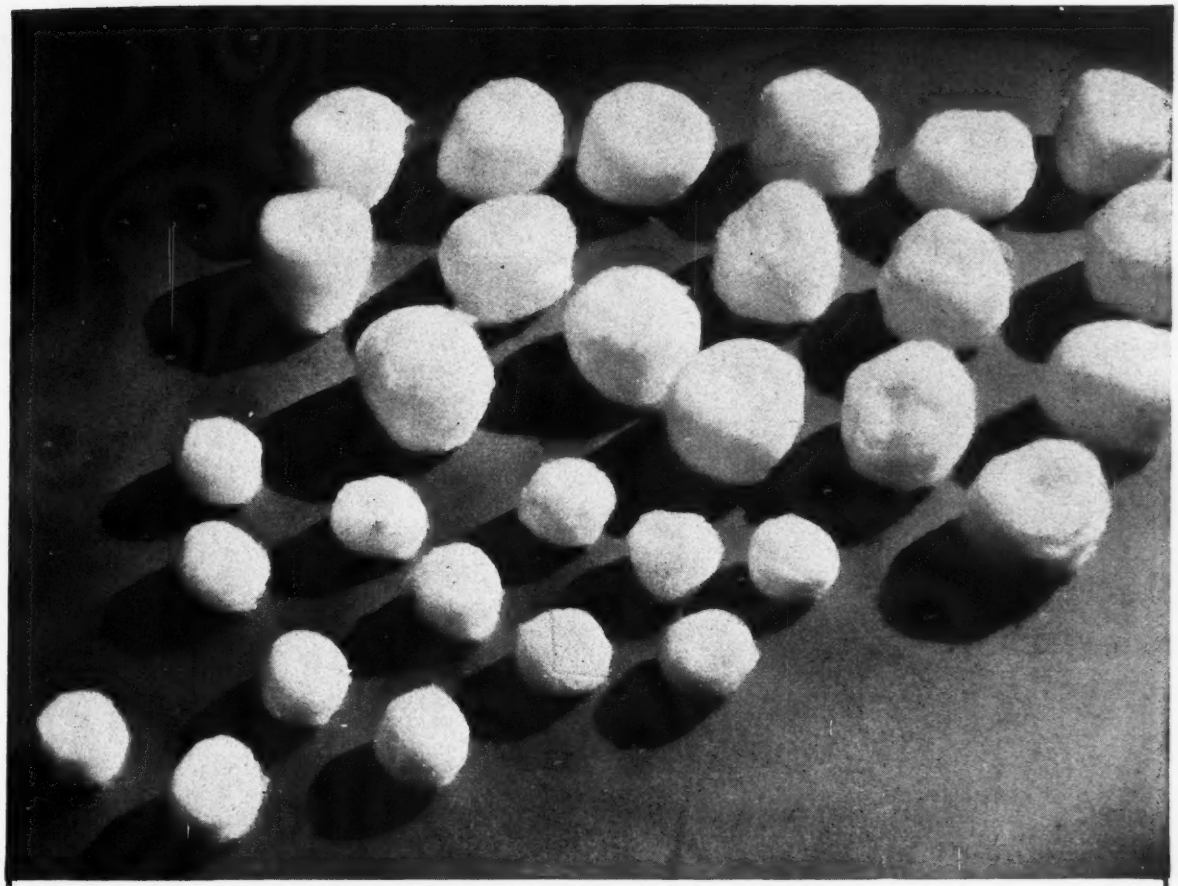

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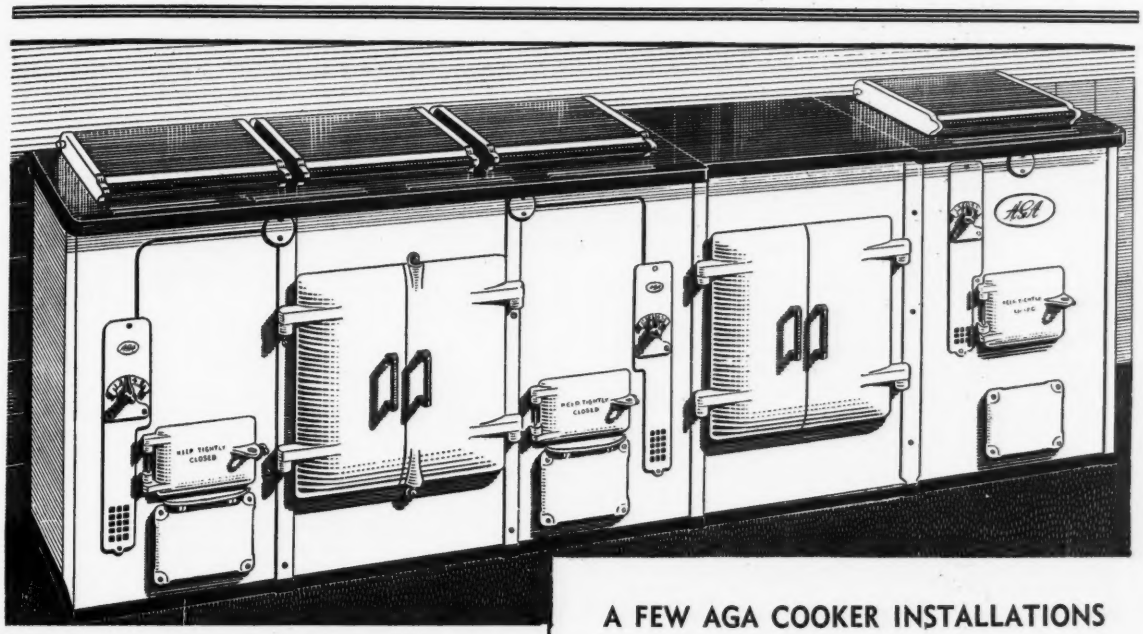

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AGA heavy duty COOKERS

Harvey Agnew, M.D.,
Editor

The CANADIAN HOSPITAL

November, 1938 Vol. 15 No. 11

Convalescent Care Passes Another Milestone in Montreal

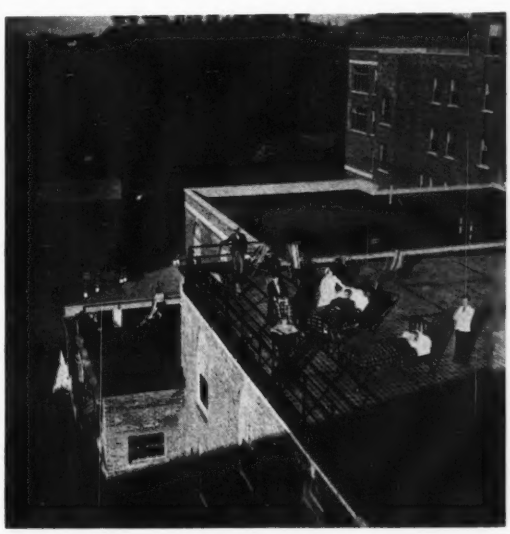
Magnificent New Addition to Montreal Convalescent Hospital

By SARA P. TANSEY, R.N., Superintendent, and
H. P. ILLSLEY, of Archibald & Illsley, Architects

IT is a far cry from August, 1914, when the Montreal Convalescent Hospital came into being—in a little, old, two-storey house with accommodation for twelve patients—to this date in 1938, when two hundred and twenty patients can be adequately cared for by this Institution.

The twenty-four years between saw many changes and much growth in the activities of this hospital, but the policy clearly enunciated away back in 1914 is still the guiding principle. The first constitution stated that "this Home was founded to provide convalescence on the recommendation of hospitals, social agencies and physicians for men and women without distinction of race or creed."

During the years 1914 to 1918, the struggle for existence was intense and only the ardour of its volunteer committee and their human interest in the "poor, discharged from hospital, with nowhere to go" kept it alive.



The first patients were mainly derelicts, for at this period the welfare organizations, with one or two notable exceptions, were not yet organized and a city refuge was almost the only door open to the homeless. A refuge indeed, this Convalescent Home to many a poor wanderer, but even then the pivotal point of convalescence was aimed at, and first class nursing care was contributed by the Victorian Order of Nurses, on call from the Home.

The work evolved, as many another work in Montreal, out of the activities of a volunteer committee—in this case, the Hospital Visiting Committee of the Loyola Literary Club. Despite the paucity of its resources, and largely due to the labours of the committee itself, the work grew and the need for its extension was more visibly seen. Hospitals became interested, doctors were no longer sceptical and in 1921 a move was made to more commodious quarters on St. Mark Street. This was a comfortable mansion where thirty patients could be given intelligent convalescence and where good food and nursing care and kindly encouragement contributed to a pleasant atmosphere.

In 1921, by legal statute the name was changed to Montreal Convalescent Home, since it was felt that the work had grown to civic proportions and that convalescence was now a well defined part of the health programme. In 1933 "Home" was changed to "Hospital" to more clearly differentiate the character of the work—it was not a home for the aged, nor a home for incurables, as many believed when applying for admission, but an actual hospital for convalescents, who after a stated period would be returned to normal life.

A Convalescent Hospital should be a distinctly hopeful place, and even if the patient must spend months in bed, as in thyroid or rheumatic heart, fracture or t.b. bone cases, the period is one of prescribed rest and not despondent inaction. Atmosphere is a determining factor in the regaining of health. If we could dispense ease of mind and a sense of economic security, fifty per cent of all our patients would instantly be cured.

The history of convalescence in Montreal, of our chapter of it at any rate, (for there is a French Convalescent Hospital, St. Joseph's) might have been good but limited had not a fairy godfather discovered us and decided to sponsor our cause. Sir Charles Lindsay urged extension and set in motion the wheels that ground not slowly but nevertheless surely into the main building of our present hospital on Kent Ave.

Just five years ago this past October (1933) the house was formally opened by the Secretary of the Province of Quebec. The city of Montreal, the provincial government, Sir Charles Lindsay, the Montreal General Hospital and the Kiwanis Club campaign contributed all told, $300,000, and this hospital of 104 beds, in a salubrious district on the city's outskirts, but convenient to the car lines, was built.

New Wing Opened 1938

Five years later, almost to the day, Lord Tweedsmuir, the Governor General of Canada, formally opened the new west wing, of 116 beds—one hundred for public patients and sixteen for private cases. Again, Sir Charles Lindsay must be thanked for this addition to our facilities, for it was by his personal subscriptions and his personal drive for funds, that this great achievement was made possible.

The provincial government, the civil authorities, the Montreal General Hospital, the Royal Victoria Hospital, the Notre Dame Hospital, the late Lieut.-Col. Molson and J. W. McConnell with a host of other generous and public spirited citizens have heeded Sir Charles Lindsay's earnest appeal and have helped to build for the sick poor of Montreal this addition to the Convalescent Hospital.

The hospital, bright and airy, well equipped, comfortable and up-to-date, has not an inch of waste space—and wonder of wonders, it has ample storage room and adequate cupboards. The architects were very patient with our demands, and woman-like, we were fussy about many things. We can truly say that this is a hospital which all the staff had a hand in planning. For instance, the dietitians conferred with architects and engineers, and the kitchen, a happy place to work in, is a composite realization, in limited space, of this concerted planning.

Co-operation of Other Hospitals

Without the one hundred per cent co-operation of all our hospitals, our work would be much more difficult, but herein lies the great virtue of the system: immediate readmission and constant follow up and close connection with the social service departments of all hospitals.

A very capable resident physician sees all patients on the day of admission, watches their progress, and, at the first untoward sign of relapse or reaction, secures readmission to the referring hospital. Orders from the referring hospital are strictly carried out, reports are made to the patients' own surgeons or physicians in those hospitals and discharge or extension of time is decreed by them. Between 45% and 55% of our patients are bed cases requiring bedside nursing and tray service. Our new wing is specially helpful here, as we have splendid tiled terraces on to which beds can be wheeled and where the sun can work its miracles of healing.

Convalescent Care

We demand much of our staff, and they give of themselves generously. Those of you who know convalescents realize how delicate is this bridge between sickness and health—a careless word, an impatient glance upsets the balance, destroys the upbuilding of days or weeks. Quiet efficiency, kindly understanding must be the essential attributes of our nurses. They must, even more than in acute hospitals, subordinate their own weariness, their eagerness for order and tidy wards to a cheerful tolerance of interruptions—a dropping of routine duties for a friendly "confab", a reassuring interview with a nervous patient. They must be firm but kindly and they must

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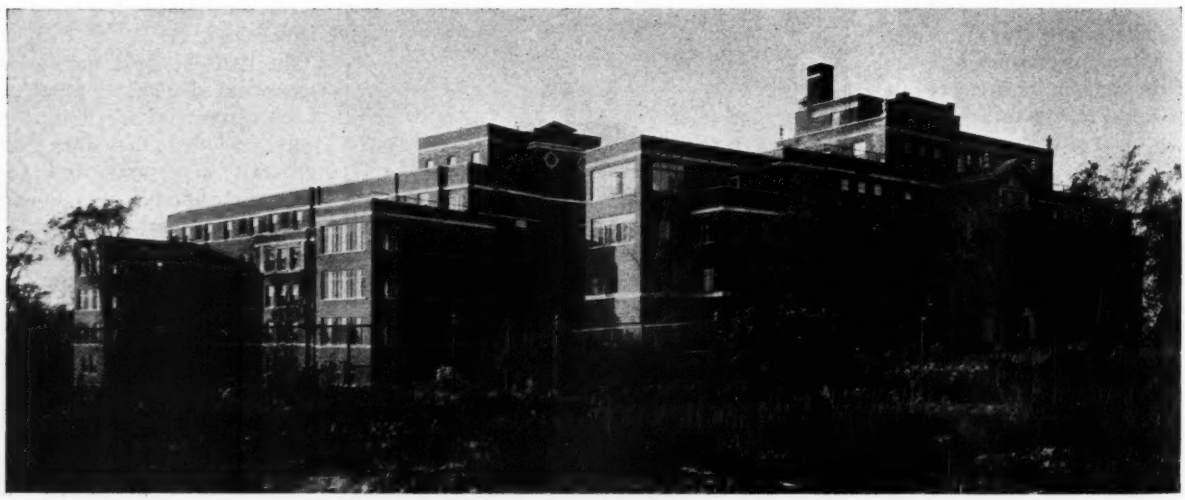

Montreal Convalescent Hospital: The new addition is to the left.

Montreal Convalescent Hospital

Upper left: Patients' Sunroom. *Upper right: Private rooms are furnished as in an acute hospital.*

Centre: The new dining room communicates with the original one through an archway.

Lower left: Well constructed inside ramps facilitate movement of patients to sun terraces. *Lower right: Some of the wards have four beds; others have eight. Gatch frames throughout.*

Convalescent Care Passes Another Milestone in Montreal

(Continued from page 16)

reconcile all the little troubles and differences of varying temperaments or various nationalities.

We hold that food is a most important part of convalescence and our dietary staff realizes the importance of its task and accepts criticism and offers suggestions for improvement in service with the same thoughtful cheerfulness.

The entire lay staff is imbued with the idea and ideals of service to the sick. Monthly conferences, in which the difficulties of maintaining a fine standard of service at a low cost are discussed, encourage co-operation.

We are planning for many activities in the new occupational therapy quarters. It will be a problem to find those best suited to our types of patients, but, with the assistance of Montreal's excellent Occupational Therapy Centre, we are hopeful of worthwhile results.

Entertainments for our patients are frequent but carefully supervised. Movies and concerts interest and please the majority, but they also excite them emotionally and sometimes disturb them and are, therefore, restricted to once or twice a month and limited to one hour. Christmas and Thanksgiving and all the feast days are observed with special meals, Christmas trees and other celebrations. The Christmas gifts are personal—knitted scarves, gloves, socks, shawls, bedjackets are collected by the Montreal Convalescent Hospital Associates (our Auxiliary). Candy, cigarettes and all the little homey touches are added. Our Auxiliary supplies many of the comforts of the hospital—ice cream treats, Christmas trees, taxis, flowers, decorations and tea parties, and gives volunteer service of many descriptions. Religious services are held weekly for both Catholic and Protestant patients.

The fifteen directors are women, many of whom belonged to the original committee of 1914. There is, also, an Advisory Board composed of representatives from the Montreal General Hospital, the Royal Victoria Hospital, The Kiwanis Club and our own committee. This Board has been most helpful in larger issues, and with their experienced counsel we have overcome many difficulties.

I have asked our architects to give you a description of the building and before turning this article over to them, in particular to Mr. Illsley, who has contributed the following details, I would extend to all and any readers of the Canadian Hospital Journal an earnest invitation to visit our hospital. We will guarantee you a hearty welcome.

* * *

PART TWO

The 1938 Extension to the Montreal Convalescent Hospital

By H. P. ILLSLEY

The original structure of the hospital, completed in 1933, provided wards for one hundred patients, with administration offices, nurses' quarters, boiler plant, kitchens, etc., all housed within the one building. The growing demand for increased accommodation to care for convalescent patients led to a decision to enlarge the building and in 1937 plans were prepared for an extension for one hundred patients in public and semi-private wards and sixteen private wards.

The problem of planning for an addition to the existing building with a minimum amount of change, and, at the same time, permitting the building operations to proceed without serious loss of accommodation to the hospital and without distress to the patients has been successfully accomplished. The only loss to the typical floors of the existing building was a small locker room adjacent to the large wards at each connecting floor.

This extension, recently completed, is connected to the original building and consists of a wing running at right angles to the original block. The building comprises five floors and basement, with a connecting arcade to the main corridors of the original structure.

Accommodation is divided into eight-bed, four-bed and two-bed wards for the public floors, with a top floor given over to private wards for sixteen patients. The private wards have private bathroom accommodation, built-in wardrobes and wash basins in every room. The set-back of the building at the upper level provides roof terraces and solaria for the private patients. The public floors have solaria at the end of each large ward and a living room is centrally planned on each floor for patients not confined to bed. These patients can also enjoy the sun decks. Each public floor has adequate lavatory and bathing facilities, as well as utility rooms, diet pantries, linen storage, etc., for the use of the nursing staff. Each patient has a private locker and the larger wards are provided with a separate locker room close to and connected to them.

The exterior design follows that of the original which is traditionally of a modified Georgian period, of selected brickwork with stone bands and stone trim as accent to significant parts of the building. Simple landscaping has been completed on the grounds, with stone-flagged walks to the various entrances. The whole aim is to lend a feeling of domesticity to the building.

Additional dining room accommodation was necessary and this was accomplished by extending the existing dining room thus giving double capacity for the patients. A room below provides dining facilities for nurses, while adjacent to it the female help and orderlies' dining rooms are located.

The existing kitchen had to be substantially enlarged to provide for the increased service and a connecting block ties in the two buildings, providing the area for increased dish-washing, pot washing and storage accommodation, while equipment has been added to the existing kitchen area in the original building. A smaller kitchen below articulates with the main kitchen and serves the nurses' and help's dining rooms.

The ground floor, in addition to an entrance lobby, provides for additional nurses' bedrooms, orderlies' rooms and extra laundry area. Adequate quarters and good daylight are provided for the occupational therapy department in the basement.

The heating plant was increased by extending the boiler room one bay and installing an additional boiler unit and its associated equipment. Heating is provided by low-pressure steam to standard exposed hospital radiators with humidifiers at selected locations.

An up-to-date system of forced ventilation ensures a

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Which is the Anaesthetic of Choice?

A comparison by point-analysis of ether, spinal and cyclopropane anaesthesia

By J. C. HOUSTON, M.D.,
Anaesthetist, Prince Edward Island Hospital, Charlottetown, P.E.I.

AT the Prince Edward Island Hospital we are using ether, cyclopropane and spinal anaesthesia in comparatively equal frequency. Looking over the records I found that up to and including the year 1933 we were using ether almost exclusively. In 1934 we began to use spinal anaesthesia more or less routinely and in November, 1936, we started using cyclopropane.

For the purposes of comparison I shall compare these anaesthetics under ten headings, assigning to each so many points. Finally these will be summarized in a grand total.

No one anaesthetic is ideal, each having certain advantages. Here is a comparative summary of their qualities.

1. Safety

Safety is one of the prime requisites of an anaesthetic; we might go further and say it is the *first essential element*. How shall we judge safety? The usual criterion, the number of deaths during the operation, is hardly fair. For instance, if the patient "bled to death" during the operation you could never charge that to the anaesthetic. Nevertheless it is always easy to attribute to the anaesthetic or its mode of administration any unusual complications which cannot be accounted for otherwise. We should take into consideration the condition of the patient prior to the operation; the time taken to perform the operation; the nature of the operation; and also the difficulties encountered during the operation in order to keep the patient within the safety-zone.

Ether has always been regarded as a very safe anaesthetic, if not the safetest of all. On the other hand there is a great diversity of opinion as to the safety of spinal anaesthesia. It has been described as safer than ether, while others assert that it is more dangerous than chloroform. Cyclopropane, being one of the comparatively new anaesthetics, has yet to make its final reputation with respect to safety.

We had one death on the operating table while administering ether. It was our opinion that the death was due to the anaesthetic. We have had more difficulty in maintaining normal respiration; this has increased since we began heavier premedication, especially if avertin has been given, and, to a less extent, after nembutal. It seems to require less ether to paralyze the respiratory centre and it is therefore necessary to watch the breathing very closely. We have less trouble with the circulatory system and I think this is largely due to our routine practice of giving intravenous saline and glucose in all operations that we think may continue for an hour or more. We do this regardless of the anaesthetic employed and in all cases where the patient is considered a poor risk.

Although we have had no deaths under *spinal anaesthesia* we did have several cases which gave us some very anxious moments. In about 10 per cent of the cases, under spinal, we experience some minor troubles, such as lowering of blood pressure, distressed respirations, and some nausea, but I have learned during the past year that a little cyclopropane will relieve these conditions. However the higher the anaesthesia the greater the danger.

We have been singularly free from worry and anxiety with *cyclopropane*, but not altogehter. The breathing is very quiet under this gas; often one must watch the bag to know whether the patient is breathing or not. This, in itself, is rather disconcerting, especially to one accustomed to giving ether. Notwithstanding this, I feel more at ease wih a patient under cyclopropane than under ether or spinal anaesthesia.

Value: Ether 90; Spinal 80; Cyclopropane 95.

2. Potency

The ability to abolish pain and spasm is another essential requisite of the ideal anaesthetic. All three will abolish pain, but they vary in their power to control spasm. There is always perfect relaxation under spinal anaesthesia. It is sometimes necessary to push ether beyond the safety-zone in order to produce the relaxation some surgeons desire. In our experience cyclopropane does not give adequate relaxation in 50 per cent of cases.

Value: Ether 90; Spinal 100; Cyclopropane 50

3. Control

Ether and cyclopropane being volatile anaesthetics are comparatively easy to control; cyclopropane, being more volatile than ether, is the more controlable. The patient is anaesthetized in less time and regains consciousness quicker. In spinal anaesthesia, if the anaesthetic effects have reached too high a level causing embarrassment of the respiration, there is no really effective means of a control; one can only wait until the effects of the drug have passed off and in the meantime combat the symptoms as they arise with artificial respiration, oxygen, and stimulants.

However, there are three means by which the segmental height of the anaesthesia can be controlled: first, by posture, second, by the interspace wherein the drug is given and third, by the amount of fluid given with the drug. We

Address given at the Halifax Convention of the Canadian Medical Association, June, 1938.

always use the third lumbar interspace if possible. After nupercain is given we raise the head of the table about 20 degrees and lower the foot. Then we very carefully watch the anaesthesia as it creeps upwards; when it reaches the desired height we reverse the table. With novocain the technique is just the opposite but the head is seldom lowered more than 10 degrees. Of the three points, posture is the most important measure. Moreover, the *time* required to reach a certain level, be it umbilicus or ensiform cartilage, varies considerably in almost every case, so that if one should keep strictly to a certain time limit, the level of anaesthesia would sometimes be too low, at other times too high.

Values: Ether 90; Spinal 50 ; Cyclopropane 100.

4. Toxicity

By toxicity we mean the toxic effects on the different organs, not the effects of overdoses or maladministration. The use of chloroform has been largely banned because of its toxicity.

From the studies of Anderson, Bourne, Raginzky and others it is apparent that we need not worry over the toxic effects of any of the three considered. However, with a patient with damaged heart or faulty function of liver or kidneys, I personally feel safer with cyclopropane than with either spinal anaesthesia or ether.

Value: Ether 90; Spinal 90; Cyclopropane 100.

The remaining sections of the yardstick can hardly be regarded as primary requisites of an ideal anaesthetic. Nevertheless they are more or less important.

5. Comfort

In this respect cyclopropane far surpasses ether and spinal anaesthesia. With it the patient falls into a natural sleep in one to two minutes and is ready for the operation in four to six minutes. There is no excitement, no struggling, no rigidity—all is peace and quietness.

Ether, on the other hand, is not an agreeable anaesthetic either from the patient's standpoint or that of the anaesthetist. There is almost always more or less excitement and rigidity with a tendency to nausea and vomiting.

With spinal anaesthesia there is a certain amount of discomfort. It is never a pleasant sensation to get a jab in the back even if it is only from a hypodermic needle. Then also it is sometimes necessary to make several attempts at different angles in order to reach the spinal canal. After the anaesthetic is given the patient often complains of a disagreeable sensation in his legs. "If I could only move my legs" is a common expression.

Value: Ether 50; Spinal 75; Cyclopropane 100.

6. Complications

The nausea and vomiting following ether anaesthesia are the two factors that have made people dread an anaesthetic perhaps more than any other. They are unconscious to a large extent of the distress during induction but they never forget the ether sickness following the operation. An anaesthetic which would banish all the distressing sequels of an operation would be a welcome addition to the armamentarium of the anaesthetist. Whether we have such an agent in cyclopropane it is perhaps too soon to say, but this is certain—that nausea vomiting, distension, gas-pains, and even pneumonia are not met with as often as with ether. Nor is there the excessive perspiration which we often see with ether. With spinal anaes-

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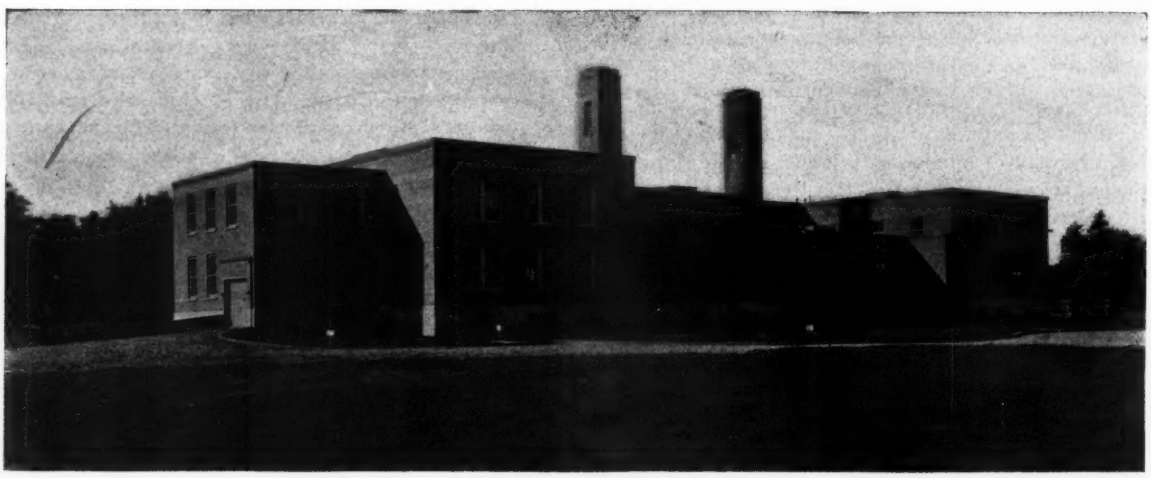
Prince Edward Island Hospital, Charlottetown, P.E.I.



This 100-bed hospital, opened in 1933, is unique in many respects. It is perhaps the most heavily insulated hospital in Canada, with the result that the heating cost has been remarkably low and melting snow has been of no trouble whatsoever on the flat parapeted roof. Also, on analysis, it sets a remarkably low record for ratio of outside wall area and of perimeter per bed, of corridor footage per bed and of length of service distances, thus reducing both capital and maintenance costs. In proportion to its area, it has nearly seven times the usual amount of sound absorbing materials. Note the ingenious arrangement whereby louvres in the square shell enclosing the round chimneys produce an exhaust system of ventilation, without mechanical device, by utilizing the heat of the chimney to creat an up-draught. This has proven effective. The simplicity of exterior design was necessitated by a reduced capital budget.

Accounting for Stores Control

By A. W. SMITH,
Riverdale Isolation Hospital, Toronto, Ontario

DOES the Hospital Administrator give this subject a great deal of thought? A properly handled stores system will prove a great asset both from a financial and business standpoint.

There are several items which should be under a Stores Control system, such as: Foods, Paints, Engineer's tools and supplies, Dispensary, Linen room, and General Stores, which should include every item that the hospital uses, and which did not come under the list mentioned above.

The Storeroom

The storeroom should be as central as possible for all sections of the hospital and at the same time should have easy access for the receiving of goods. Good ventilation and dryness at all times are important. The danger of fire in the storeroom should be recognized and adequate precautions taken. The storeroom should be large enough to handle the situation properly. The shelves or compartments should have ample space to take care of a large amount of stock for each item. Each item should be numbered numerically, and run in rotation.

Storeskeeper

An efficient storeskeeper should be in charge of the storeroom. He must be tidy at all times and realize his responsibility to the hospital.

Who Should Have Access to the Storesroom?

If the storeskeeper is to be held responsible for his stock, it seems quite logical that there should be as few keys as possible for this room. Three keys should be sufficient: one each to the Storeskeeper; Hospital Administrator and Night Supervisor; the latter for emergency supplies only.

Issuance of Supplies

The storeskeeper must not give any article out of the storeroom without a properly signed Stores Requisition. This rule should be strictly adhered to and should apply to everyone up to and including the Hospital Administrator.

I suggest the using of Stores Requisitions which do not show any description of article ordered. This type of requisition simply shows the quantity to be ordered, the unit of same and the stores number. (See figure No. 1).

Every item handled in stores, no matter how small it be, should be properly named and described, classified according to expenditure, be given a stores number, and set up in a stores book. (Fig. 4).

Every department of the hospital should have a Stores Book which is always up to date. If any new item is added to or old item discontinued in stores, a typed memorandum should be sent to each section of the hospital so the adjustment can be made.

When making out the requisition the stores book should be consulted for correct number, because the storeskeeper will fill only the numbers listed on requisition. After the requisition has been made out it should be signed by person made responsible. All requisitions should be sent to stores ledgerkeeper who checks them as to correct signature and if correct will number them numerically. The stores ledgerkeeper enters the numbers of requisitions on a receipt for requisitions and receiving slips form (See figure No. 2). The storeskeeper will check requisition numbers with form and if correct will sign for requisitions.

The storeskeeper will fill each item on the requisition carefully. The storeskeeper or ward porters will deliver supplies where they will be checked off and person receiving goods will sign name in space alloted on requisition. When storeskeeper is filling stores requisition and finds he is out of an item asked for, he should fill out a stores shortage notice (see figure No. 3), which form will show quantity, article and stores number of goods that were ordered. This notice will accompany the delivery from stores to the section of hospital requisition came from.

When stores requisitions have been filled by storekeeper, and signed for by receiver, they should be returned to accounting office at the end of the day accompanied by receipt for stores requisitions and receiving slips form, where the stores ledgerkeeper will check numbers of requisitions that have been filled and if found to be satisfactory, stores ledgerkeeper will sign for them.

Receiving of Goods

One of the first things to consider is the storeskeeper. If he is to be the general receiving clerk, he will receive all supplies except food, which is usually handled directly in conjunction with the kitchen.

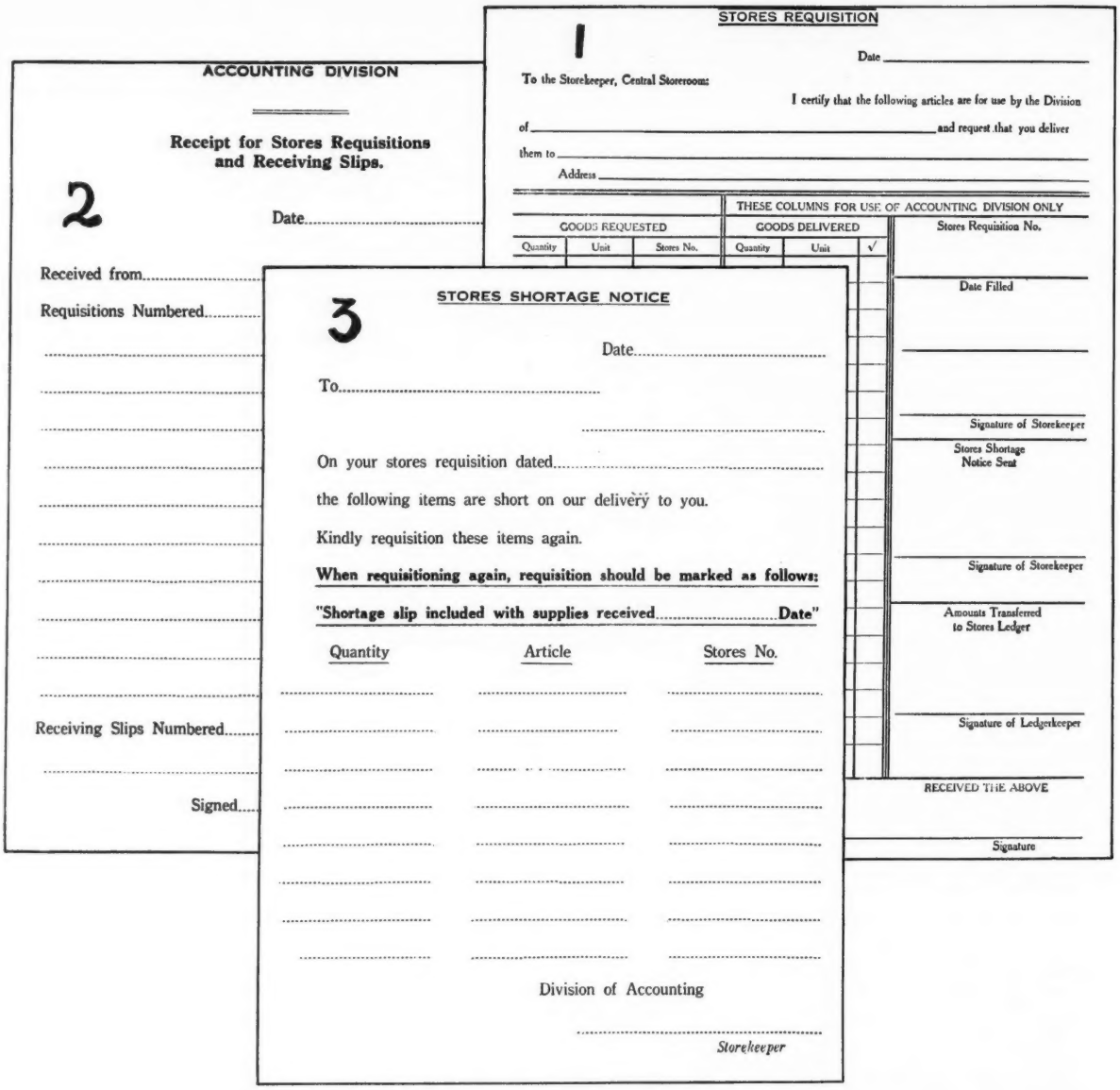
We will consider that the storeskeeper is to be the general receiving clerk for the hospital. The storeskeeper should make out a receiving slip for all goods received, after carefully checking goods with invoice slip. The amount received should also be checked with copy of order.

It is very essential that the storeskeeper check goods as to quality before actually making out receiving slips.

If the goods are correct as to quality and amount, the date goods were received and storeskeeper's initials should be entered on his copy of order.

Receiving slips should be made out in triplicate for all goods that remain in Storesroom. Original accompanying invoice to accounting office for payment; duplicate to stores ledgerkeeper for posting into ledger; and it is advisable to have the storeskeeper mark on this copy the amount of goods that were on hand before new supply was received into stores. This gives the stores ledgerkeeper an extra chance to check the amount on hand with ledger, and if not in balance a check can be started at once to locate difference; triplicate to remain on file in storesroom.

Receiving slips should be made out in duplicate for



STORES REQUISITION

1

Date _____

To the Storekeeper, Central Storeroom:

I certify that the following articles are for use by the Division

of _____ and request that you deliver

them to _____

Address _____

			THESE COLUMNS FOR USE OF ACCOUNTING DIVISION ONLY		
GOODS REQUESTED			GOODS DELIVERED		
Quantity	Unit	Stores No.	Quantity	Unit	√

Stores Requisition No.

Date Filled

Signature of Storekeeper

Stores Shortage Notice Sent

Signature of Storekeeper

Amounts Transferred to Stores Ledger

Signature of Ledgerkeeper

RECEIVED THE ABOVE

Signature

ACCOUNTING DIVISION

Receipt for Stores Requisitions and Receiving Slips.

2

Date.....

Received from.....

Requisitions Numbered.....

Receiving Slips Numbered.....

Signed.....

STORES SHORTAGE NOTICE

3

Date.....

To.....

On your stores requisition dated.....

the following items are short on our delivery to you.

Kindly requisition these items again.

When requisitioning again, requisition should be marked as follows:

"Shortage slip included with supplies received.....Date"

Quantity	Article	Stores No.

Division of Accounting

.....

Storekeeper

goods received by storeskeeper which are not to remain in storesroom. Original with invoice to the accountant for payment, and duplicate to remain on file in storesroom.

All receiving slips should be numbered numerically. The number or numbers of the receiving slips going to the stores ledgerkeeper should be entered on receipt for stores requisition and receiving slips form. All receiving slips and filled requisitions should be taken to stores ledgerkeeper at the end of each day. The numbers of receiving slips and requisitions should be checked with receipt for stores requisitions and receiving slips form and if found to be correct should be signed by stores ledgerkeeper. This receipt protects the storeskeeper in that he has returned all requisitions that are filled and that receiving slips have been made out.

If goods are for stores and found to be satisfactory, they should be numbered with their stores number and placed on proper shelf or compartment in storesroom. If goods are not for stores and have been found to meet all specifications, they should be taken by storeskeeper or porters to section of hospital for which they were ordered, and person receiving goods from storeskeeper should sign receiving book in column alloted for this.

The receiving book should be used for goods received by storeskeeper, which do not go into stores. This book is really the storeskeeper's only check that he delivered goods to department for which they were ordered, and that they were received and signed for. The receiving book should show:

Date goods were received by storeskeeper.
Firm who sold goods.
Quantity received.
Description of goods.
Section of hospital goods are for.
Signature of person who received goods from storeskeeper.

If goods are bulky or difficulty in handling necessitates their being delivered directly to engineer's section, laun-

dry, etc., the storeskeeper must be called to sign for receipt of goods. In other words, the only signature accepted by the accounting office as authority for proper receipt of goods should be that of the storeskeeper, and all dealers or messengers delivering goods must be instructed to make delivery of goods to storeskeeper, and to him only. If absent, owing to illness or on vacation, person taking his place shall sign storeskeeper's name per their own in full.

Complaints re shortages, defective goods, or goods of inferior quality must be made to the purchasing section in writing by the storeskeeper, not later than the day following receipt of goods. Storeskeeper must retain on file the carbon copy of his letter of complaint.

Ordering of Goods for Stores

The ordering of goods for stores is the stores ledgerkeeper's responsibility. The storeskeeper should not have anything to do with it, unless the system is very small and the storeskeeper gives out supplies as well as keeping a perpetual inventory.

Every item in stores has a ledger sheet in the stores ledger. This sheet should show:

Name of article.
Stores number.
Unit of item.
Classification number for expense purposes.
Maximum and minimum of stock.

Required number of columns necessary for allocating the expense to various sections of hospital.

The stores ledgerkeeper should post all filled requisitions and receiving slips received from storeskeeper. When any item reaches the stated minimum a purchase requisition should be made out in triplicate. The amount of goods to order will be the difference between the maximum and minimum. It is very essential to keep the maximum and

(Continued on page 48)

Article and Description	Unit	Min.	Max.	Classification No.
Bowls, Pots, Pans, Jugs, Pails & Trays				
Bowls, Mixing, W.E., Rd. Bottom, Deep, 11½" Diameter	Piece	2	5	1251
Bowls, Mixing, W.E., Flat Bottom, 9½" Diameter	Piece	2	5	1252
Bowls, Mixing, W.E., Flat Bottom, 10½" Diameter	Piece	2	5	1253
Bowls, Mixing, W.E., Flat Bottom, 11½" Diameter	Piece	2	5	1254
Dishpans, B/W.E., Round, 12"	Piece	2	–	1256
Double Boilers, Aluminum, 1 qt.	Piece	2	–	1258
Double Boilers, Aluminum, 2 qt.	Piece	2	–	1259
Double Boilers, W.E., 2 qt., No. 53	Piece	2	5	1260
Double Boilers, W.E., 3 qt., No. 54	Piece	2	3	1261
Frying Pans, Aluminum, 6½", No. 307	Piece	2	–	1262
Frying Pans, Aluminum, 8½", No. 308	Piece	2	–	1263
Inserts, Aluminum, 5"	Piece	2	–	1264
Inserts, Aluminum, 6½"	Piece	2	–	1265
Inserts, Aluminum, 8½"	Piece	2	–	1266
Inserts, W.E., 10 qt., No. 24	Piece	2	–	1267
Jugs, W.E., 1 pt.	Piece	2	5	1268
Jugs, W.E., 1 qt.	Piece	2	8	1269
Jugs, W.E., 3 qt.	Piece	2	5	1270
Jugs, W.E., 6 qt.	Piece	2	5	1271
Pails, W.E., 10¼" dia.	Piece	2	5	1272
Pails, W.E., 11½" dia.	Piece	2	5	1273
Pie Plates, W.E., 10", No. 11	Piece	2	14	1274
Preserving Pots, W.E., 15½", No. 40	Piece	2	–	1275
Preserving Pots, W.E., 16½", No. 50	Piece	2	–	1276
Pudding Pans, Round, W.E., 1¾" x 5½"	Piece	2	8	1277
Pudding Pans, Round, W.E., 2" x 8½"	Piece	2	8	1278
Pudding Pans, Round, W.E., 3"x12½"	Piece	2	5	1279
Pudding Pans, Round, W.E., 2½" x 6" No. 1	Piece	2	8	1280
Pudding Pans, Round, W.E., 2½" x 8" No. 2	Piece	2	5	1281
Pudding Pans, Round, W.E., 3" x 8½ No. 3	Piece	2	5	1282
Pudding Pans, Round, W.E., 3¼ x 11", No. 6	Piece	2	5	1283
Pudding Pans, Oval, W.E., 7¼" x 11" No. 13	Piece	2	5	1284

Fig 4. Page from Stores Book

Charter Session of New House of Delegates of A.H.A.

The outstanding feature of the Dallas meeting was the inaugural session of the recently created House of Delegates representing all of the states and provinces in the two countries. A fair number of Canadians participated in these sessions, although the long trek south meant that several of the provincial delegates elected during the summer were not able to attend. Unless a special session be called for emergency reasons, the next session of the House of Delegates will be held in Toronto next year. This is the legislative body of the Association.

Beautiful New Hospital in Annapolis Valley

By A. E. RICHARDSON, R.N., Lady Superintendent

THE Blanchard-Fraser Memorial Hospital, opened at Kentville, Nova Scotia, on August the 31st, is one of the finest small hospitals in the east. Colonial in design and beautifully situated at the west end of the town, the hospital provides accommodation for 31 adult patients, 8 children and 7 infants.

The *ground floor* is at present given over to living quarters for the staff of graduate nurses, staff dining room, kitchen, maid's dinette, laundry, frigidaire and storage space and the infectious disease ward. A sub-basement provides further storage room. The main kitchen, large and airy, is well equipped with all modern conveniences and has stainless steel sinks, drain boards and shelves. There are, in addition to the main kitchen, diet kitchens on each floor.

The *first floor* is occupied by administrative offices, public waiting room, with toilet room and telephone booth, doctors' library, cloak room and toilet room, the drug room, superintendent's rooms, private rooms and wards. Elevator service is furnished from the ground floor to the top floor.

The 7 private rooms are furnished in pastel shades of rose, green, mauve and blue; the 2 semi-private rooms have walnut furniture and champagne coloured curtains. Private and semi-private rooms have connecting baths and toilets. The public wards, which comprise two five-bed wards and two three-bed wards for men and women and two four-bed wards for boys and girls, have walnut furniture and coffee coloured hangings. Comfortable Morris chairs are supplied for each room and ward. All rooms and wards have running water and there is a bathroom off each children's ward. Utility rooms and separate bedpan rooms are placed conveniently at either end of the corridor to save steps and make for efficient nursing.

On the *top floor* are two operating rooms, for major and minor operations, with connecting sterilizing room, scrub room and doctors' room. Across the hall from the main operating room is the X-ray department including a portable X-ray apparatus.

The maternity case room, the nursery, accommodation for six maternity cases and a sun room are also on the top floor. The nursery, which contains seven bassinettes, is finished in blue and has rose hangings—making a very effective room for our new arrivals in Kentville. There is, too, a special bathroom for new born infants with thermostatic control on the bath. The sunroom, at the west end of the floor and available to all patients, gives a wonderful view of the valley and Cape Blomidon.

On the day of the formal opening over 900 of the guests present signed the register after an inspection of the building. The public are greatly pleased with the hospital, and favourable comments are received from all sources, as to the location, equipment, and service available to the people residing in this valley.

A.C.S. New York Meeting Most Successful

The Hospital Standardization Conference of the American College of Surgeons at the Waldorf-Astoria, October 17-21, was one of the best yet. Dr. MacEachern had arranged a very timely and practical program which attracted a record attendance. On one afternoon with two round tables proceeding simultaneously dozens were unable to gain admittance. Many fine addresses dealing with personnel, nursing, the physical plant, blood banks, hospital insurance, etc., were given. There were symposia on obstetrical care, anaesthesia, training for admistration and surgical training as well as a joint session with the Association of Record Librarians of North America. The demonstrations of administrative and technical procedures in a number of the leading hospitals proved very popular. A large number of administrators, staff members and nurses from Canada were in attendance and a number took part on the program or in the discussions.

Blanchard-Fraser Memorial Hospital

Blanchard-Fraser Memorial Hospital

Top centre: A dignified and colourful flight of steps lead up from the lobby.

Left centre: The four-bed wards have the very latest in equipment.

Right centre: Comfortable quarters are provided for the nurses.

Bottom: The kitchens are modern and fully equipped.

National Hospital Day Awards

The awards for the best National Hospital Day programs have been announced by the National Hospital Day Committee of the American Hospital Association.

Cities over 15,000 population

Winner: City Hospital, Cleveland, Ohio.

First Honourable Mention: New England Sanitarium and Hospital, Stoneham, Mass.

Cities of less than 15,000 population

Winner: Paradise Valley Sanitarium Hospital, National City, California.

First Honourable Mention: Waynesboro Community Hospital, Waynesboro, Virginia.

The competition was keener than ever this year and the standards set were considerably in advance of standards prevailing but a few years ago. Some remarkable community programs were reported. Unfortunately, no Canadian hospitals were among the prize winners this year, but it is hoped that they will be represented next year.

Obiter Dicta

Father Verreault's Departure

IT is with mingled feelings of regret and of pride that we record the departure from Canada of the honoured president of the Canadian Hospital Council, Rev. Georges Verreault of Ottawa. Father Verreault sailed on October 28th, on comparatively short notice, to take up more or less permanent residence in Rome. All of us who have had the privilege of knowing and working with this slim, quiet, unassuming, yet brilliant and dynamic person realize that we personally are to lose the companionship of a true friend and counsellor and that our Canadian Hospital Council, in losing its President, a member of its Editorial Board and the Chairman of one of its most important committees, that on Accounting, will be particularly hard hit. A young organization like this Council, which a few months ago saw its enthusiastic Editor resign at the call of broader fields, will sorely miss this second indefatigable worker. We are indeed grateful for all that he has done for the hospitals in this country and elsewhere.

However, our loss is the gain of others. It is a real tribute to Father Verreault's ability and a distinct compliment to this country that Father Verrault should have been called upon by his Order, Les Missionaires Oblats de Marie Immaculée, to standardize the accounting of the 25 Provinces or Districts of the Oblate Order throughout the world. This will probably mean considerable world travel, his headquarters being the Bursar-General's Office in Rome. This is indeed a high honour and one in which all of his friends rejoice. Most sincere wishes for a long and successful career in his broader field of activity go to Father Verreault from his countless host of friends throughout this continent.

Le départ du Rév. Père Verreault

C'est avec regret que nous apprenons le départ du Président du "Canadian Hospital Council", le Rév. Père Georges Verreault, d'Ottawa. Le Rév. Père s'embarquait pour Rome le 28 octobre, où il s'établira plus ou moins définitivement. Tous ceux d'entre nous qui ont eu le privilège de connaître le Rév. Père et de collarborer avec cet homme calme, sans prétention, mais brillant et enthousiaste, réalisent que personnellement nous perdons un véritable ami et conseiller, et que notre "Canadian Hospital Council" en voyant partir son président, un membre de son "Editorial Board" et le "Chairman" d'un de ses plus importants comités, celui de la comptabilité, subit une lourde perte.

Une organisation naissante comme ce "Council" qui, il y a quelques mois voyait un Editeur enthousiaste présenter sa résignation devant de nouveaux travaux d'extension, perd ce second travailleur infatigable à qui nous sommes reconnaissants pour tout ce qu'il a fait en vue des hôpitaux de ce pays et d'ailleurs.

Tout de même notre perte est un gain pour les autres. C'est un hommage rendu au R. P. Verreault et un honneur pour notre pays que le choix du Rév. Père comme réviseur du système de comptabilité des 25 provinces ou districts des "Missionnaires Oblats de Marie Immaculée" répandus par tout le monde.

Cette charge lui occasionnera de nombreux voyages dans les deux continents; cependant ses quartiers généraux seront au "Bureau de l'Econome Général" à Rome.

C'est, à la vérité, une grande marque de confiance dont tous ceux qui l'ont connu se réjouissent. Ses nombreux amis du continent américain forment des voeux, pour que sa carriére dans ce nouveau champ d'action ouvert à son activité soit fructueuse et consolante.

The Next Step in Hospital Care Insurance

WHAT may be a significant step in the development of hospital care insurance was that taken at the recent Dallas convention of the American Hospital Association by its newly formed House of Delegates. This body initiated a movement which may eventually lead to the recognition and approval of voluntary hospital care insurance plans which would provide not only hospital care to their members but would cover their medical care while they would be in hospital as well.

This step was taken primarily because of an increasing demand on the part of the medical staffs of many hospitals that they be included in these plans. Medical societies are studying and, in some cases, are prepared to sponsor, group payment plans to cover medical fees for patients of limited means. If carried through, it is felt that such an arrangement would return to private medical service in hospitals a large group now going to hospital on the public service.

The American Hospital Association has offered to cooperate with these medical societies and the American Medical Association by setting up principles whereby plans offering medical care inclusion and which have been approved by the local medical society can be evaluated. As a basis of negotiation the following principles have been set forth:

1. Sponsorship and control by non-profit organizations, representative of hospitals, the medical profession and the public.
2. Free choice of physician and free choice of hospital consistent with existing relations between approved hospitals and their physicians.
3. Financial soundness and adequate accounting.
4. Equitable payments to physicians and to hospitals.
5. Separate finances and reserves for hospital care and for medical services of attending physicians.
6. Hospital and medical service benefits determined by hospitals and the local profession.
7. Dignified promotion and administration.

This would seem to be a forward step and a timely one. It was inevitable that medical care should be proposed for inclusion in these plans. This has been anticipated by both hospital and medical associations. The essential point is that such development should be directed and controlled by the hospitals and their medical staffs themselves rather than be directed by those who are not primarily interested in the welfare either of the hospitals or their medical staffs. By setting up principles, compliance with which will safeguard the interests of all parties concerned, much potential difficulty in the future can be thwarted.

The principles enumerated would seem to be sound. The existing freedom of choice of hospital and of physician is maintained, yet there is no interference with the staffing policies of the hospitals concerned. In this country in many mining and other areas we have had prepayment plans for both hospital and medical care for some years. On the whole these have proven eminently satisfactory. The rapidly growing Associated Medical Services plan in Ontario combines both benefits and is proving a distinct advantage. A wider adoption of these joint types of voluntary sickness insurance might do a great deal to forestall the demands of so many people for the more radical compulsory health insurance.

Again the Football Season

FOOTBALL is one of the grandest games ever developed, that is, when it is played on the football field. When it is introduced into the hospital field and the hospitals themselves become booted around as the footballs, the game becomes a travesty. Such games have been going on in more than one centre recently, but the one which is now in what is obviously the last quarter and which must soon be settled one way or the other is being played in Toronto with three or four very active hospitals jointly furnishing the pigskin.

These hospitals have incurred an ever-increasing deficit as a result of undertaking a larger proportion of charity service than their private services would warrant. In the case of one of the hospitals, the present deficit on city patients alone amounts to over $70,000 and is rapidly increasing. This, of course, is above the statutory payment for public ward patients, which, reasonable as it is, happens to be considerably below the actual cost of the service provided. Despite early presentation of these claims, no provision was made in the 1938 estimates for their payment and, at the same time, payment for outpatient service was reduced. The city claims that the province must meet these deficits, while the province in return puts it up to the city. In the meantime the hospitals are paying on increasingly heavy overdrafts to keep going.

It is utterly absurd that the hospitals should have to be the football in this battle between province and municipality. The Public Hospital Act compels these institutions to accept every patient applying and suitable for admission. Having spent the money on their care, as compelled to do so by law, it is not the concern of the hospital whether the city or the province pay the deficits. Trustees and administrators of these hospitals have enough worry maintaining the efficiency of their institutions without having to assume added worry over these mounting deficits. The citizens receiving the treatment were residents of both the municipality and the province.

Municipal and governmental officials should keep in mind the tremendous load of responsibility which voluntary bodies and philanthropy in general have taken off the public purse. Kill that spirit of voluntary aid and one shudders to think of the consequences. Already there is ample evidence that the spirit of benevolence is half-killed, at least.

If this business of passing the responsibility from one to the other goes on any longer, these and other hospitals will find it necessary to close their public wards, as was seriously threatened recently in Winnipeg. Voluntary bodies cannot continue to operate these services at a loss beyond what they can meet. Such action, if continued, would compel the municipality to build a municipal hospital, the deficits for which, if efficient service be maintained, would soon far exceed the present deficits. While such action is most undesirable and would be a terrible hardship on the poor, leading probably even to the death of many, it would seem that only by such action can any proper solution of this controversy be achieved. Should such drastic step be necessary, it should be clearly understood by all—*the responsibility for forcing such closure of the public wards and out-patient services cannot be laid upon the hospitals.*

Note: As we go to press we ascertain that of the $104,451 requested to cover the 1937 deficits, the City Council has agreed to pay $44,468 upon the distinct understanding that there would be no further requests to meet the 1938 deficits already piled up, or to meet other deficits in the future.

When is it a Disgrace to Balance the Budget?

THIS question was raised at the annual dinner of the American College of Hospital Administrators by Dr. Goldwater, who deplored the satisfied complacency with which many administrators and trustees view their balanced budget. The accomplishment, creditable though it may be, by no means indicates the suitability of these individuals for their responsibility. It may mean that too many of them are looking upon the task of hospital administration purely as a business, as a glorified form of hotel keeping.

There is a good deal in this viewpoint. True, it may be

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A Record Librarian at Large in New York

Tenth Annual Conference of the Association of Record Librarians of North America

By VERA E. DALE, Registrar
Association of Record Librarians of Ontario

THE good fortune that had befallen me in being appointed delegate from the Association of Record Librarians of Ontario to the Tenth Annual Conference of the Association of Record Librarians of North America was brought to mind more and more as we entered the famous Holland Tunnel into that great metropolis, New York City. On through Greenwich Village, across the brilliantly lighted Broadway and into midtown New York, and so completing a delightful motor trip through the beautiful country which comprises the states of Pennsylvania and New Jersey.

Monday, up bright and early to register, and during the morning kept the New York police busy supplying directions to the various places of interest. The luncheon at noon for the members was very delightful and the speaker had chosen a most appropriate subject, "Women and Peace". She apologized for knowing practically nothing of the Association and its activities, but this was not hard to understand when she stressed a need for tolerance in the so-called "weaker sex", because every medical record librarian fully understands the meaning of the word "tolerance", especially as applied to her work.

MISS VERA E. DALE

Department of Hospital Service, Canadian Medical Association; Registrar, Association of Record Librarians of Ontario.

An interesting feature of one of the sessions was a symposium on "Office Technique, Procedures and Management", the high light of which was a demonstration of the photographing of case records for the purpose of conservation of storage space, the amount of space conserved being ample justification for such procedure.

An aeroplane accident seriously affected our joint session with the American College of Surgeons when we lost the chairmanship of Dr. James T. Nix. The plane in which he was travelling caught fire, but, fortunately, the capable pilot in charge was able to land safely at midnight by the light of flames from the fire—without injury to his passengers.

In one paper it was pointed out that the record room was no place for strict formality; if the doctors could relax and talk easily, better records would result. Every department in the hospital should fully understand the work of the record room. The small hospital was shown to be a storage house for medical research, but the major obstacle would seem to be the lack of qualified personnel. The small hospital, however, is just the hospital that needs a well trained record librarian, who could perform more than one major duty. Good records are indispensable and could be obtained in the small hospital through the employment of qualified personnel. The classified nomenclature of operations in use at the New York Hospital was described. The topographical part of the Standard Nomenclature was used and operations were classified under such headings as excision, incision, resection, amputation, introduction, repair, manipulation, inspection, etc.

Among the faults in record writing which make them of no scientific value, another speaker went on to say, were such statements as, "Family history—negative", "Past history — irrelevant," "Usual childhood diseases." The past history of a patient is never irrelevant, and this is especially true in heart cases. Childhood diseases should always be noted. The complaint should be given in the patient's own words. In writing the physical examination, the words negative" and "normal" have no place.

It was stressed that a good many findings of value were missed because the intern knew the diagnosis and was inclined to make the history fit the diagnosis, rather than make the diagnosis from his own findings. An instance was cited of a study of 4,000 obstetrical cases, with a view to studying haemorrhage, in which only ten cases showed any record of haemorrhage. This was due entirely to omission. Another doctor on the programme spoke of the uses of the medical record in clinical research, and emphasized the fact that the medical staff would never be on its toes unless the record room was a "live room". Such charts as "mortuary charts", or those just filed away to allow the dust to collect on them, were of no value.

We spent one afternoon at the mammoth Columbia-Presbyterian Medical Centre, where we learned that the record room personnel at the Presbyterian Hospital worked twenty-four hours a day, in three shifts, and that over three thousand charts were pulled daily.

Other sessions were devoted to papers covering the

nursing department, medical social service department in relation to the record department, administrative practices and policies of the record department, qualifications and responsibilities of the medical records librarian, unit record system, follow-up system, and a splendid address on case studies of tumors. There was also a very humerous skit on the presentation of case records at court.

The banquet, attended by over two hundred members and guests, was one of the bright spots of the Convention. It was happily presided over by that most suitably named Master of Ceremonies, Mr. Robert Jolly of Houston, Texas. Entertaining speakers and a delightful musical programme added greatly to the success of the occasion.

On the closing day the record departments of the New York Hospitals were again the centre of interest, the Committee on Arrangements providing tours to the various hospitals.

The Tenth Birthday Convention of the Association of Record Librarians of North America is one that will long be remembered by those in attendance. Friday evening came all to soon and regretfully I found myself again passing through the Holland Tunnel, but happy in the thought of the added knowledge and experience gained and the memory of a very pleasant trip.

Interns from Unapproved or Unrecognized Medical Schools Being Accepted in Canada

Graduates of unapproved or unrecognized medical schools in the United States are trying to get into Canada in increasing numbers and a number have been accepted for internship this year by our hospitals. The reason for this unusual interest in Canadian hospitals for the past couple of years is probably the fact that they have been denied internship in hospitals approved for internship in the United States. As the National Board of Medical Examiners (U.S.A.) requires internship in an approved hospital before granting its diploma, recognized in 43 states, as do also nearly half of the individual state licensing boards, and as internship in an approved Canadian hospital is recognized by the National Board as a credit, it follows that many of these graduates of unapproved or unrecognized hospitals see their opportunity to qualify for state licensure through internship in an approved Canadian hospital.

The Executive Committee of the Canadian Medical Association agreed two years ago that it would not give approval for intern training to any hospital accepting such graduates. Obviously to do so would at once cancel the happy reciprocal arrangements now prevailing and by reason of which our hospitals obtain many interns who have graduated from leading medical schools in the United States. The Council on Medical Education and Hospitals of the American Medical Association has been making strenuous efforts for many years to stimulate better medical education and to eliminate the poorer schools. A great deal has been accomplished and only a few unapproved or unrecognized medical schools now remain. All Canadian medical schools are approved.

Owing to the increasing shortage of interns, it is difficult for hospitals to refuse these applications, if their quota be incomplete, but the Canadian Committee on Approval will have no alternative but to automatically suspend or remove from the approved list any hospital accepting such graduates. Such action was found necessary last year. Doubtless many of these young men and women have fine personal qualities, but if their medical training is not good enough for internship in United States hospitals, it is not good enough for our patients here. In case of a medico-legal action, too, the hospital would be in a bad position.

Graduates of the following medical schools are ineligible for internship in a hospital approved for intern training:

Unapproved medical schools:

Chicago Medical School, Chicago.

Electic Medical College, Cincinnati.

Unrecognized medical schools:

Middlesex College of Medicine and Surgery, Waltham, Mass.

College of Physicians and Surgeons, Boston.

Illinois College of Physicians and Surgeons, Chicago.

Kansas City University of Physicians and Surgeons, Kansas City, Mo.

Mid-West Medical College, Kansas City, Mo.

North-Western Saskatchewan Hospital Association Holds Successful Meeting

Under the presidency of Mr. F. R. Beggs of Wilkie a very successful one-day conference was held, on October the 26th, of the hospitals in the north-western part of Saskatchewan. The meeting was held at Wilkie and was largely attended. A very busy day session kept the delegates active from morning until evening. Addresses were given by Mr. E. N. Carter, Chairman of the Wilkie Hospital Board; Rev. A. Schaller, O.M.I., and Mrs. J. D. Lewin of Reward, on "Women's Auxiliary Work"; Rev. Sister M. Cita, St. Joseph's Hospital, Macklin, on "Hospital Problems". There were two question periods, one led by Miss J. E. McMillan of Kindersley and the other by Mr. Harry Boden, Reeve of R.M. No. 439, Cut Knife. The Round Table discussion on hospital problems was led by Mr. A. Esson of Rosetown. The programme was concluded by a board of trade dinner and entertainment in the evening.

This is the third year for this district conference. It has again proven the value of these district meetings to create interest in local hospital problems and in the work of the provincial association.

Another British Columbia Coast Hospital Meets Isolated Community's Need

(The material for this article has been taken from letters written by Dr. H. A. McLean, Secretary, and Mr. Percy E. Wills, President, of the Nootka Mission General Hospital in affiliation with The Shantymen's Christian Association, at Ceepeecee, B.C., and the July "Nootka Missionary Review".—Ed.)

IN these days, building a new hospital is a serious business. It often takes—and necessarily so—months of planning, weeks of campaigning, seemingly endless unwinding of red tape, and countless meetings, with a good deal of squabbling thrown in, till the day when an exhausted but beaming staff and board open the doors of their hospital to the public. But there are still, in this country, a good many hospitals which are being built as pioneer ventures, with cornerstones of faith, hope and charity. Nootka Mission General Hospital is one of these and its brief history is a refreshing and interesting one.

In the area which the hospital covers — a 100 mile stretch of coast line, with a population of some 1,500 persons, the majority of cases needing hospitalization are those of organic trouble. Neurosis seldom comes under the diagnosis and cases of sickness are usually of smaller percentage than in city hospitals. Since the local population is employed for the most part, in hazardous pursuits, such as mining, logging, millwork and construction, there is a number of emergency cases which brings the percentage of general operations to a higher ratio. The field of mining, with its accompanying silicosis, and occasional outbreaks of seasonal diseases, often presents a mass type for treatment, rather than isolated cases.

Transportation is a serious problem for both the hospital and the patient. A car is of no use, for the one road in the territory runs from the beach to the mines at Zeballos, some five miles only in length. All travel is by water—a necessarily slow method in comparison to the fast traffic of city highways. For instance, one woman, with a fractured elbow, who lived only 20 miles away was six hours in reaching the hospital. By that time the swelling around the locality of the fracture was so pronounced that it necessitated stringent methods of treatment before the cast could be put in place. With mail boats ten days apart the medical worker is often seriously handicapped in not receiving appliances and pharmaceutics just when they are needed. It is only in the most serious cases that an aeroplane is employed.

The original staff of Ceepeecee: Miss B. Weller, R.N., Matron; Miss R. Portway, Nurse; H. Shannon, Orderly, and H. A. McLean, M.D. ,Physician.

However, only a year ago there was no hospital at Ceepeecee. During the summer months of 1937, Dr. H. A. McLean and Mr. Percy E. Wills, missionary for the Shantymen on Vancouver Island, went up and down the coast of Vancouver Island, visiting "nooks and out of the way places, caring for some hundreds of cases in such places as are never visited generally by medical help". Ceepeecee was one of these places. Dr. McLean was confronted with cases of purpueral septecaemia, fractures, dislocations of the elbow, subtrochanteric fractures of the femur, fulminating appendicities, blood poisoning, cardionephritics—and even drugs had to be brought in from Vancouver, on a boat which called once in ten days.

The two men were convinced of the need of a hospital and, in Dr. McLean's words, "Percy and I went to work". It was not an easy task that they had set themselves. About one hundred yards along the beach from the new Esperanza Hotel they built their "hospital", a 14 by 32 ft. building, made from lumber presented by the Nootka Wood Company. When funds came in, a second building the same size was added to serve as staff quarters. Dr. McLean and Mr. Wills finally found it necessary to go to Vancouver and Victoria, and there they collected enough money to provide an X-ray unit. Later a third building was added, larger and much more impressive by reason of a second storey. Another building was added in the spring to serve as a schoolhouse and in the spring, too, a boat was acquired. As early as July, 1938, electric wiring was being installed and water had been laid on through a 1200 foot pipe down the creek.

Hospitalization of the Indians is a serious problem. Percy Wills writes: "There is quite a large number of Indians in the territory sadly in need of

Left: This photograph gives some idea of the wild but beautiful British Columbia coastline.

Right: A close-up of the hospital.

attention. Few hospitals will touch their need, and those that do will handle only accident cases, and none, or few, of illness. We have been agitating for quite some time that action be taken on behalf of the natives, and now it looks as though we shall have a separate hospital to deal with the problem of the red man".

At present the medical and hospital staff consists of Dr. H. A. McLean and Dr. Charter, who arrived in Ceepeecee in May, Miss Weller, a registered nurse and superintendent of the hospital, and her assistant, Miss Portway, and Mr. Harold Shannon, the orderly. Dr. McLean writes proudly that during June, July and August the hospital cared for 49 cases, including burns, septicaemia, appendicitis, sub phrenic abscess, pneumonia, fractures of every bone in the body but the pelvis, cardio-renal failures, pre-eclampsia, etc., etc. During April, May and June, 24 patients were cared for in the hospital and 157 patients were given treatment outside the hospital. All this has been accomplished where, a few months ago, was a veritable wilderness, and in spite of the serious financial difficulties which accompany a missionary project.

There are, of course, both advantages and disadvantages to this hospital "pioneering"; for instance, "the question of fuel becomes one of sweat and tired muscles rather than outlay of finances". An enthusiastic summer bulletin announced that "the paint is due to arrive at any time and will add greatly to the enchantment of the spot". The hospital building proper may not bear the architect's critical gaze, but, nestled there beneath the tall pines and shining peaks, it is man's best guarantee for a return to health.

Galt, Ontario, Puts Hospital Care Insurance Into Effect

The Galt Hospital Service Society at Galt, Ontario, recently incorporated under a provincial charter, is now receiving applications for contracts. Hospitalization will be provided at Galt General Hospital.

Individual contract holders pay an annual payment of $9.00, payable at 75c. per month. The rate for husband and wife is $12.50 per year; for family of four, $15.00; and for a family of seven, $16.80 per year. The individual contract provides for 21 days of hospitalization—a maximum value of $63. For longer care, a 25% discount on the usual hospital rate is made. Twenty-one days of obstetrical care are provided for the wife, but, in other than obstetrical cases, only 50% of the hospital charges for 21 days is met. After that time a 12½% discount is extended, whereas in the obstetrical case the 25% discount is effective after the first 21 days. Benefits for children are similar to those for wives. Benefits to the wife and family are limited in this way because of the small increase in premium charged for family coverage.

The Round Table Forum

3. Is a Hospital of 40 Beds Justified in Employing a Dietitian?

Miss Winifred J. Moyle, President Canadian Dietetic Association. (Reply approved by Executive Committee of the Canadian Dietetic Association.)

Yes. A 40-bed hospital should be conducted as satisfactorily for the patient as a larger unit. Therefore, the patients and doctors in a smaller community should have the services which a qualified dietitian only can offer. If the duties of a dietitian and housekeeper be combined, this should come within the salary budget and her training will allow for intelligent buying and management of hospital supplies and equipment.

Miss Jennie H. Sullivan, Superintendent, Harbour View Hospital, Sydney Mines, N.S.

I cannot see that the employment of a dietitian is justifiable in an ordinary 40-bed hospital, where, as a rule, the staff are all graduate nurses who have acquired a knowledge of dietetics in their training and earlier education. The saving to the hospital by such an appointment would not nearly meet the salary, and the efficiency gained would be negligible in proportion. There really is nothing to occupy the time of a dietitian in a hospital of such size unless her duties be associated with some other activity of the institution.

Mrs. E. B. Rutter, Head of the School of Household Science, University of Saskatchewan, Saskatoon, Saskatchewan.

Decidedly yes. The recovery and health of the forty patients depends not only upon a high standard of nursing and medical care, but also upon suitable and appetizing food. The dietitian is the only one in the hospital personnel who knows the science, art and psychology of satisfactory feeding. Dietetics is required for the R. N. degree. Surely a qualified instructor is a necessity.

A good dietitian saves the hospital's money while providing better meals.

She is qualified to assume food purchasing, housekeeping and technician duties."

Miss V. Bengtson, Superintendent, Eastern Kings Memorial Hospital, Wolfville, N.S.

No. In the average general hospital of this size there are, usually, not many special diets, and there is not sufficient work to justify the expense of a dietitian.

A good cook and one graduate floor nurse, who, with her other work, has charge of the diets and serves all meals—avoiding the mistake made by some hospitals in allowing any nurse not occupied at the time to serve the meals—should prove satisfactory.

There are hospitals with even several dietitians whose food is both badly cooked and served. No matter how carefully a diet is worked out, if it is not appetizing the patient gets little benefit from it.

Rev. Sister M. Cita, Secretary, St. Joseph's Hospital, Macklin, Saskatchewan.

A forty bed hospital is justified in employing a full time dietitian for the simple reason that it has the same variety of special diets as the large hospital. On the other hand, hospitals that size are generally financially handicapped, at least at the present, and are unable to employ full time or even part time qualified dietitians. But they should at least have somebody experienced in diets who has been previously under the supervision of a qualified dietitian.

Question for next month:

"Do you require a written consent before any operative procedure be undertaken?"

Moncton Hospital Care Plan Completes Successful First Year

The Group Hospitalization Service Commission of Moncton, New Brunswick, which is entering on its second year of operation, has issued a report for the first year of operation, ending August the 31st, 1938.

Total participants in the scheme for the year numbered 660, of which 203 were male, 252 female and 205 children. Of this total, 10.15% received hospitalization, including 12 men, 37 women and 18 children. The number of hospital days was 621—an average of 9.3 days per person hospitalized. The major weakness was the paucity of groups but the commission hopes to bring in some of the bigger companies in its second year.

Dr. H. H. Mitchell Passes

It is with deep regret that we report the passing of Dr. H. H. Mitchell, late superintendent of the Regina General Hospital, who died on October the 14th. Dr. Mitchell was well known in hospital work and was a very active member and past president of the Saskatchewan Hospital Association. Before succeeding Dr. S. R. D. Hewitt as superintendent of the Regina General Hospital in 1932, he was medical director of the cancer clinic in Regina and he had been for many years coroner of Regina. Dr. Mitchell, a resident of Regina for the past twenty-five years, was born in Niagara Falls, Ontario, and was graduated from the University of Toronto. The hospital field has lost an administrator whose conscientious devotion to duty accomplished a tremendous amount in keeping his institution in the forefront of hospital development. He was widely and favourably known in hospital and medical circles throughout Canada.

Here and There in the Hospital Field

By THE EDITOR

IT is not always a matter of congratulation to have a celebrity occupy a room in one's hospital. The other day Stanley Howe of East Orange told us that a well-known pugilist spent ten days in his hospital. During that time they received 9,000 calls concerning his welfare, 1,500 being received in one day. Many of those who called up refused to believe the operator when she reported that he was still alive, and caused considerable delay by trying to argue with the hospital authorities that he was dead. An extra operator had to be added to the switchboard staff. On many occasions the ten trunk lines were all congested with calls, and they had to obtain as high as eight policemen at one time to clear the traffic. However, as Stanley said: "We would have had to pay a lot to get the advertising space that this case gave us."

* * *

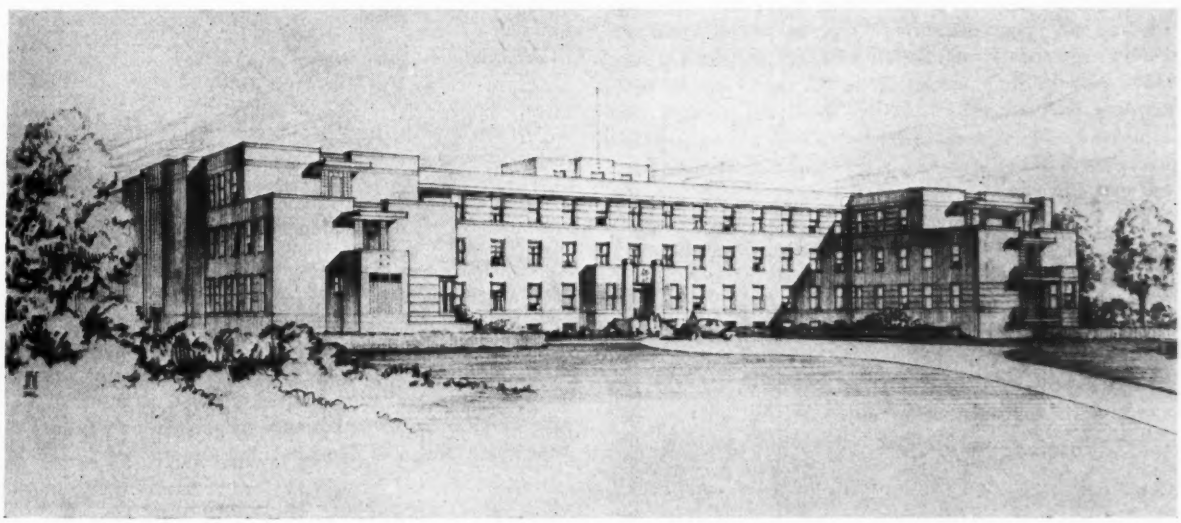
A warning has been issued respecting the technique in drawing blood samples when motorists or others are suspected of being under the influence of alcohol. Dr. E. R. Frankish, Ontario medico-legal expert, found a very high incidence of alcohol (3.8 parts per 1,000) in the blood of a motorist who, when arrested, had not shown any clinical signs of intoxication such as the blood test finding indicated. On investigation he had found that the person's arm had been sterilized with alcohol, and it was not clear whether or not the needle had been wiped with absorbent cotton soaked in alcohol. Owing to the increased advocacy and use of alcohol blood tests to determine intoxication in motor accidents, it was urged that alcohol must never be used as a sterilizing agent, either on the skin or for the needle and syringe. The amount of alcohol required to raise the alcohol content of the blood sample to the ratio considered as indicating intoxication is exceedingly small.

* * *

"It is unfortunate that the price of an article of diet goes up when it is found to be of value to prevent or cure disease", stated Sir Edward Mellanby, the Secretary-General of the Medical Research Council of Great Britain, in one of his lectures on Nutrition now being given in various centers of Canada, under the auspices of the Canadian Medical Association. Shortly after the value of liver as a cure for pernicious anaemia was discovered, he sent his assistant to purchase some liver. The butcher's supply was completely exhausted, and the customer was informed it was because of this new "suspicious anaemia". In a burst of commercial inspiration, the butcher urged the assistant to suggest that his master find a disease that could be cured by the use of "sheeps' heads" of which he had at least twenty lying unsold.

In urging the greater use of breast feeding for infants, he emphasized the factor of resistance to disease, which is imparted by breast milk to a greater extent than its artificial substitutes. Also he called attention to the three good reasons for breast feeding advanced by a 14-year old girl essayist in a home nursing class, who favoured

Verdun Protestant Hospital Nurses' Home



The Nurses' Home, when finished, will provide accommodation for 108 nurses, including sitting rooms, reception rooms, kitchenettes and lecture room. An Infirmary Unit contains 6 beds, utility room, kitchen, etc.

breast feeding because "It is cheaper, it keeps better over the week-end, and the cat can't get at it".

* * *

Mr. David Williams of Collingwood, the President-Elect of the Ontario Hospital Association, has been honoured by the hanging of his portrait in the city hall at Collingwood. This recognition of his long service as councillor and mayor of his city is a fitting tribute to one who has contributed so much to the life of his province. Mr. Williams is particularly well known for his interest in Canadian history. A past president of the Ontario Historical Society, he has devoted a great deal of his time and energy to historical research and was largely instrumental in the establishment of the excellent Huron Institute at Collingwood, a museum which is filled to overflowing with an enviable collection of articles illustrating the life of that part of Ontario in bygone days. As one writer has stated, "If by Mr. Williams' example inspiration were given even one amateur historian in each township to collect and preserve local folklore, the professional historian of the future would have a wealth of material ready for his task".

* * *

The barbecue at the Dallas convention called for some wholesale catering on the part of "Barbecue John Snyder", the nationally famous cowhand who directed the proceedings. To feed the 3,000 people who were present at the barbecue, the cooks provided 14 beeves, 300 pounds of beans, 200 pounds of onions and 30 gallons of pickles. While most of the delegates chose cold drinks, because of the heat during the week, those who did take coffee consumed 30 gallons of cream and 6,000 cubes of sugar. The meat was remarkably tender and the cattle had been chosen by "Barbecue John" himself, who insisted upon having white-faced cattle, nine months old. The beeves were suspended on spits in an open pit, from 4 a.m. that morning, and at no time were they exposed to live flame, glowing hardwood charcoal from a nearby fire being placed in the pit at frequent intervals.

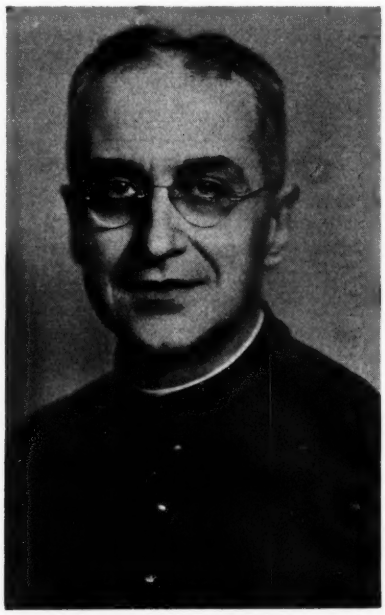
* * *

One of the most delightful "success stories" that we have heard in a long time is that which Miss Jean I. Gunn told the 800 and some nurses of the Toronto General Hospital Alumnae Association at the silver anniversary dinner given in her honour. In what amounted to a public confession to Sir Joseph Flavelle who, twenty-five years ago, was Chairman of the Board of Trustees of the T.G.H., Miss Gunn revealed that a pretty hat was perhaps the chief factor in her appointment as superintendent of the Nursing School at the Toronto General.

When she was asked to appear before the Board of Trustees of the T.G.H., her fellow nurses at Morristown Memorial Hospital, N.J., objected violently to the hat she was wearing. Said Miss Gunn: "I had no decent hat and no way of buying one, so the entire nursing staff combed the whole hospital, and I arrived in Toronto with the best hat in the hospital. I think the hat won Sir Joseph's heart".

* * *

The Provincial Royal Jubilee Hospital at Victoria prides itself on its accuracy of records and inventory. Last year the total invoices of goods received by the central stores, exclusive of hardware and drugs, amounted to $125,000.00. A comparison at the end of the year with the requisitions, plus the inventory value of the stock on hand, left a difference of .075%, or less than $100. This could be easily accounted for by the loss of perishable fruits.



REV. Fr. GEORGES VERREAULT, O.M.I.,
President, Canadian Hospital Council.

Father Verreault was recently appointed to the Bursar-General's Office of the Oblate Order to standardize the accounting of the Oblate Order districts throughout the world. He sailed October 28th to take up residence in Rome. Father Verreault will have to visit, in all probability, most of the "provinces" of his Order throughout the world and anticipates a heavy but most interesting assignment of duty. His forwarding address is:

Generalate of the Oblates of Mary Immaculate
5, Via Vittorino da Feltre, 5
Rome, Italy.

(See also Editorial)

Graham Stephens Appointed

Mr. Graham F. Stephens has accepted the position of assistant superintendent at the Evanston Hospital, Evanston, Illinois. Mr. Stephens is the son of Dr. George F. Stephens, superintendent of the Winnipeg General Hospital, Winnipeg, Manitoba. He is also a graduate of the Hospital Administration Course at the University of Chicago which is sponsored jointly by the University and the American College of Hospital Administrators.

Elk Point Hospital, Alberta, Opens New Wing

The official opening of the new wing of the Elk Point hospital took place on October the 8th.

Ontario Hospital Association News

ERECTION of the proposed new addition to the Brantford General Hospital was a step nearer realization, following the monthly meeting of the Board of Governors on Oct. 13th, when appointment of Harold J. Smith, Toronto, as special architect for the hospital, was ratified and instructions given to him to prepare detailed plans for the addition. These plans are to be submitted at an early date to the Board of Governors, preparatory to calling for tenders.

Kingston General Hospital will shortly receive about $30,000 from the estate of Minnie (Wallace) Johnston of New York.

The Stratford Branch of the Canadian Legion has forwarded a cheque for $150 to the Stratford General Hospital to be used as a fund for maintenance of the "iron lung" and oxygen tent provided for the institution in a recent campaign conducted by the Legion.

Report in London, Ont. press, states that the Victoria Hospital building scheme has taken a new turn. It is proposed now to raise by private subscriptions $150,000 in order to erect an eighty-storey building which will meet the needs of the institution. At present there is available from various sources $680,000. It is felt by adding to this, the $150,000 mentioned above, that there would then be enough available to erect a building that would satisfactorily meet the situation.

Reinstatement of Dr. George H. Stevenson and Dr. J. R. McGeoch to the staff of the Ontario Hospital, London, Ont., is reported.

The Hospital for Sick Children, Toronto, is bequeathed 200 shares of the capital stock of the Bank of Commerce, by the late Thomas Henderson Wood.

Mount Hamilton Maternity Hospital, opened only recently, already has almost half its bed accommodation occupied, it was reported on October 15th.

On October 17th, the Stratford Medical Association announced that a medical staff had been drawn up for the local hospital. This staff organization was brought about as a result of the recommendation of the American College of Surgeons.

The Douglas Memorial Hospital, Fort Erie, has requested that the matter of a fixed grant of $2,000 per year for the hospital be submitted for the consideration of the ratepayers in the forthcoming municipal elections.

Gratifying is the announcement that only $300 is needed to complete payment for the $40,000 addition constructed at Peel Memorial Hospital, Brampton, last year.

Miss M. MacMillan of Port Hope, appointed superintendent of McKellar General Hospital, Fort William, succeeding Miss Barbara Bell, took over her new duties on October 1st. Miss Winnifred McKinnon has been appointed superintendent of the Fort William Isolation Hospital to take the place of Miss Ruth Cameron, who resigned.

J. H. Rush, a director of the Soldiers' Memorial Hospital Board at Tillsonburg, has announced that immediate steps will be taken to erect a $30,000 wing 60 by 90 feet.

Miss Lillian I. Uren, eleven years superintendent of Parkwood Hospital, London, Ont., has resigned.

—F. W. Routley, M.D.

WOMEN'S HOSPITAL AIDS ASSOCIATION

Province of Ontario, Canada

Association formed 1910 *Individual Aid formed 1865*

The Central Council Hospital Aid of the Freeport Sanatorium, Kitchener district, held its seventeenth annual meeting on October 20th, at the Freeport Sanatorium. Reports revealed wonderful work accomplished, six thousand dollars being raised by the various groups; three thousand, nine hundred and thirty dollars being raised alone in the sale of Christmas Seals. It was reported by the superintendent of the Freeport Sanatorium that there are one hundred and forty-seven patients representing a total of nineteen nationalities. Very extensive Aid work has been accomplished by these groups during their years of service to this institution.

* * *

Brantford Women's Hospital Aid held its annual meeting recently when splendid reports were given of the year's work. The sewing groups were particularly active; Group Number 1 making two thousand nine hundred and fifty articles; Group Number 2 making two thousand seven hundred and eighty-nine articles; Group Number 3 making seven hundred and ninety-seven articles; Group Number 4, one thousand, three hundred and seventy articles; Group Number 5 making eight hundred and seventy articles.

The Hospital Aid Tea Room which is conducted in the hospital for the convenience of those who find it necessary to visit the hospital has proven the fulfilment of a real need. The total number of lunches prepared in the tea-room during the year totalled two thousand, three hundred and twenty-nine. There were twenty-six thousand, five hundred and twenty-five customers served. This entire work is carried on by the Aid members.

During the year the Aid supplied weekly treats of ice-cream for the public ward patients and provided special treats for public ward patients at the various seasons; re-decorated the superintendent's sitting room, purchased new hymn books for the nurses' classroom. The children's wards received regularly flowers, books, etc., to brighten the days for the children. A scholarship was presented at the graduation exercises. The Aid assisted in National Hospital Day on May the twelfth. One of the meetings during the year took the form of a luncheon in the nurses' dining-room, after which the members were taken through all the service parts of the hospital,

(Continued on page 36)

Course in Hospital Administration at University of Toronto for Graduate Nurses, December 5th to 10th

A course in hospital administration for registered nurses is being given by the School of Nursing at the University of Toronto during the week December 5th to 10th.

The course will include lectures, demonstrations and round tables on various aspects of hospital administration. Some of the instruction will be given in the School of Nursing and some of it will be given in the larger hospitals.

The following aspects of hospital administration will be covered:

Organization

Fundamentals; government regulations; medico-legal aspects; organization and management of the smaller hospital.

Financial

Support and control; accounting methods; purchasing and stores.

Physical plant and department administration

Maintenance; food service; central supply room; medical records.

Hospital relationships

Hospital personnel; medical organization and relationships; public relations.

The staff of the School of Nursing will be assisted by a number of Toronto hospital administrators and others, and several lecturers from outside Toronto are contributing to the program.

Application must be made to Miss Nettie Fidler at the School of Nursing, Queen's Park, accompanied by the remittance of the course fee of $7.00. This will be refunded if the applicant cannot attend the course and the request be made before the course opens.

This course is being given in response to the desire on the part of many hospital administrators, particularly those of small hospitals for an opportunity to study administrative methods. The institutes and other short courses now held annually in Chicago and in several other centres have proven exceedingly popular, and this short course has been arranged to obtain some idea of the extent of the demand for courses in administration in this country.

Faculty of Nursing, University of Toronto.

Ontario Hospital Association News

(Continued from page 35)

functioning. Warm praise was given to the various women's institutes for upkeep of wards under their name, also for special treats to patients, a chicken dinner being provided the nurses for Thanksgiving.

The Treasurer reported five hundred and five dollars and sixty-one cents in the bank; bonds $10,500.00, Disbursements for the year $7,177.45, Receipts for the year $5,739.09.

The superintendent expressed gratitude to the Aid for the splendid assistance given, also the chairman of the Board of Governors and the secretary-treasurer of the Board of Governors kindly commended the Aid work. The Provincial President was the guest speaker and expressed commendation for splendid work attained during the year. Deep regret was expressed in the passing of Mrs. T. H. Preston, who organized the Brantford Hospital Aid, also a former faithful worker, Mrs. A. G. B. Tisdale, and for the regrettable passing of Mr. Oliver Rhynas and Doctor C. G. Chapin.

Montreal Homeopathic Hospital Campaign Nets $303,233

A fine record of service and the untiring support of loyal friends and workers made the recent campaign of the Homeopathic Hospital of Montreal an outstanding success, when the $250,000 objective was passed by more than $50,000.

The hospital plans to build a $100,000 Nurses' Home which will release the second floor of the hospital now used as a residence and thus increase the bed capacity by forty-four beds. Beside the furnishing of this floor for public and semi-private occupancy, an additional case room is to be supplied in the maternity department, increased accommodations in the X-ray department, the operating room is to be enlarged, out-patient facilities to be improved and debts will be liquidated.

Vancouver General Hospital Adopts Arbitration Award

The adoption of the award of the arbitration board in the recent wage dispute has been announced by the Vancouver General board and will, according to reports, boost operating costs of the hospital some $20,000.

Montreal General Hospital Offers Further Accommodation

The 6th, 7th and 8th floors of the Western Division of the Montreal General Hospital were opened for occupancy in October. These floors were laid out but not furnished when the building was erected a few years ago in anticipation of increased demand for additional accommodation. All of the rooms are private rooms and their opening adds a possible 75 to the capacity of the hospital, bringing the total of the Montreal General Hospital up to 675 beds.

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

II. The Blanch

● Previously, we have described the reasons for the thorough cleansing of raw food materials prior to canning and the methods by which such cleaning is effected. Another basic operation in the commercial canning procedures for many vegetables and some fruits, is known as the "blanch". (1)

In essence, the blanch is an operation in which raw food material is immersed in warm or hot water, or exposed to live steam. The blanch serves a multiple purpose.

First, blanching serves to soften fibrous plant tissue. By so doing, it contracts or expands these tissues and thus insures a proper final fill in the tin container. Second, during the blanch, respiratory gases contained in the plant cells are liberated. This release of gas prevents strain on the can during heat-processing and favours development of a higher vacuum in the finished product.

Third, the blanching operation inhibits enzymes naturally present in the raw foods and prevents further enzymatic action. Inhibition of enzymes — particularly those inducing oxidative reactions, yields products of superior quality and nutritive values. Fourth, the blanch may serve as an added cleansing measure and also remove "raw" flavours from certain foods. A final function of the blanching operation is to fix or set the natural colour of specific products.

In commercial canning practice, blanching is usually accomplished in equipment especially designed for certain types of products. In general, the raw products after thorough washing are conveyed through water or steam by various mechanical devices capable of adjustment so as to subject the raw materials to a particular temperature for the proper period of time.

Such, in broad detail, are the purposes and mechanics of the blanch, a basic operation in many commercial canning procedures.

(1) 1937 Appertizing or The Art of Canning, A. W. Bitting, The Trade Pressroom, San Francisco.

O.H.A. Convention Highlights

By FRANCES CAMPBELL

THE unfortunate absence of the President, Mr. A. J. Swanson, whose attendance at the 15th annual convention of the Ontario Hospital Association was prevented by illness, was a matter of keen regret to each and every delegate. The outstanding success of the convention, held in Toronto at the Royal York, Nov. 1-3, was, however, a constant reminder of the tremendous amount of work which he and the other officers of the association had put on the program during the year. The convention registration reached 600, and Dr. F. W. Routley, secretary-treasurer of the association, reported some of the largest section meetings in the history of the Ontario Hospital Association.

> *If people are not properly taken care of when they become sick, if adequate facilities for both medical and hospital care are not provided for them in the early stages of their sickness, we may anticipate having in increased number chronically ill people on our hands who will gradually become a complete charge on the public. The government should be vitally concerned in keeping these people well.—President A. J. Swanson.*

Dr. Fred W. Routley in his report to the members stated: "We are well within our rights in stressing to the government and to municipalities that neither now, nor ever, have the actual costs of the indigent sick been paid out of the public funds. We must constantly educate public opinion. We must constantly do everything in our power to get the public to understand what hospital cost and efficiency means to the province and what hospital care means to the public."

A record number of splendid commercial and educational exhibits made a fine display and completely filled two large halls.

Dr. Malcolm MacEachern, guest speaker at the luncheon, listed six cardinal principles for efficient hospital administration — organization, co-ordination, co-operation, efficiency, economy and service—and gave ten criteria for gauging the service rendered by the hospital to the community.

Dr. Smirle Lawson, Chief Coroner of the City of Toronto and Supervising Coroner of the Province of Ontario, spoke on medical autopsies. Dr. Lawson stressed the serious responsibility assumed by the physician undertaking a post-mortem and emphasized care in the preparation of objects or organs for examination.

Three papers dealing with medical social work as a vital health service, observations from a year's experience in the operation of a convalescent hospital, and understanding the chronically ill, were effectively grouped. "The medical social worker is no longer a luxury but an economy," said Dr. MacEachern in commenting on Miss J. M. Kniseley's paper. Beautiful surroundings, pleasant environment and recreational leadership to give confidence were points stressed in convalescent care by Rev. Sister Beatrice of St. John's Convalescent Hospital, Toronto. Miss Merle Watson, of St. Peter's Infirmary, Hamilton, classified the different types of chronic patients and the different approaches which must be used in nursing care of these patients.

Dr. B. T. McGhie, Deputy Minister of Hospitals for the Province of Ontario, presented a paper reviewing the recent amendments to the Public Hospitals Act and those of the Public Health Act affecting hospitals.

Problems concerning interns were discussed by Dr. S. Ryerson, Assistant Dean, Faculty of Medicine, University of Toronto, and Dr. Harvey Agnew. The open discussion was led by Dr. A. H. Sellers, Medical Statistician of the Department of Health of the Province.

The Hon. Harold J. Kirby, Minister of Health of the Province of Ontario, and guest speaker at the banquet, reviewed the distressing economic situation which has prevailed since the Great War. Canada's particular difficulty, he stated, "is to create a condition of confidence in our situation in our institutions and in our economic system, so that we can be stimulated to go ahead and provide better livings for ourselves than are available in people of other countries. . . . We cannot be exempt from the great hazards of the international situation. We *can* correct our own internal troubles by a more penetrating examination and review of public administration."

Dr. Hannah's paper on Medical Services Incorporated reviewed the successful history of that service, and a round table on "Common Problems of Administration", led by Dr. Dobbie of the Weston Sanatorium, closed the open sessions of the convention.

Election of Officers

Hon. President, Dr. J. H. Holbrook, Hamilton; Hon. Vice-President, Mr. A. J. Swanson, Toronto; President, Mr. D. Williams, Collingwood; President Elect, Dr. L. C. Fallis, London; 1st Vice-President, Mr. C. J. Decker, Toronto; 2nd Vice-President, Mrs. O. W. Rhynas, Burlington; Secretary-Treasurer, Dr. Fred. W. Routley.

* * *

Four Timely Suggestions

Provisional grants should be graded. The large city hospitals, many of them accepting medical students for clinical teaching, operating training schools for nurses, having out-patient departments, and providing the very latest in the way of scientific equipment and expert personnel are called upon to give a more costly service than is required of small hospitals. It is said that there would be political dynamite in grading grants. I cannot see that politics should enter into the question at all. There should

(Continued on page 40)

INDIVIDUAL TOWELS PREVENT WASHROOM INFECTION

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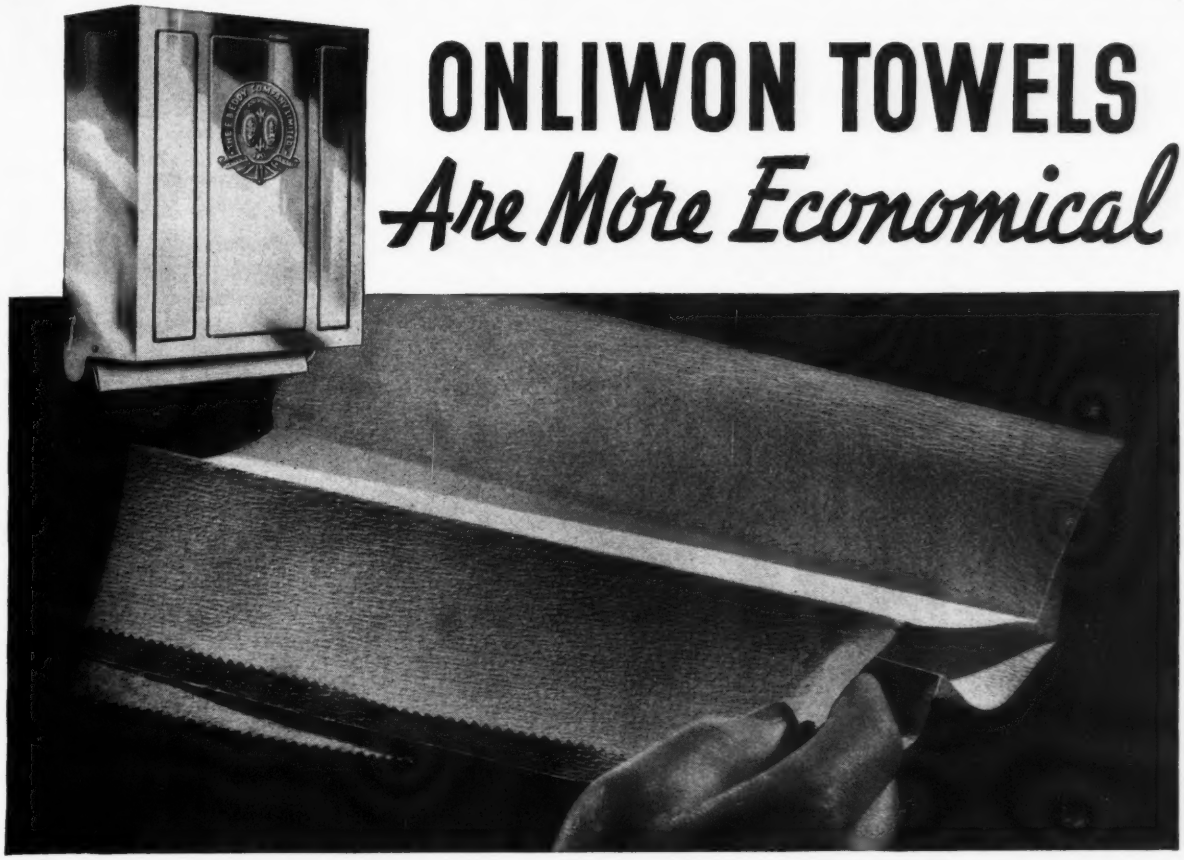

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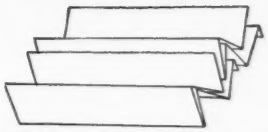


The foolproof "interfold" prevents the cabinet feeding more than one Onliwon towel at a time.

Fabric "stretch" makes Onliwon towels tougher and more absorbent. They don't go to pieces in wet hands.

ONLIWON TOILET TISSUE

Pure, soft, sterilized. The first interfolded tissue on the market and always the best value. Cabinets in white enamel, chromium or nickel finish.

be no more dynamite in the grading of hospitals than in the grading of schools.

—Arthur J. Swanson.

* * *

Efficiency begins with the individual hospital worker, whether he be physician or pantry-boy. Just as the members of the medical staff are chosen only after they have presented credentials showing their fitness, so, too, should the non-professional personnel give some proof of their ability. Would it be too much to ask the latter to take intelligence tests of a type that would demonstrate their ability to understand orders and to think quickly? Business firms find these simple tests of value in weeding out incompetent employees. Then why not the hospital, where lives depend upon the keen-mindedness and alertness of the workers?

—Malcolm T. MacEachern, M.D.

* * *

Has the time come when hospitals should also establish Training Schools for Interns? As a matter of fact, is not this precisely what is provided for in the recommendations being made for Intern Education? If it is, then the most necessary feature required by the hospital, if it is to follow the experience of nursing education, is to establish a School for Intern and Resident Training and appoint a Director or Superintendent in charge of it.

—Stanley Ryerson, M.D.

* * *

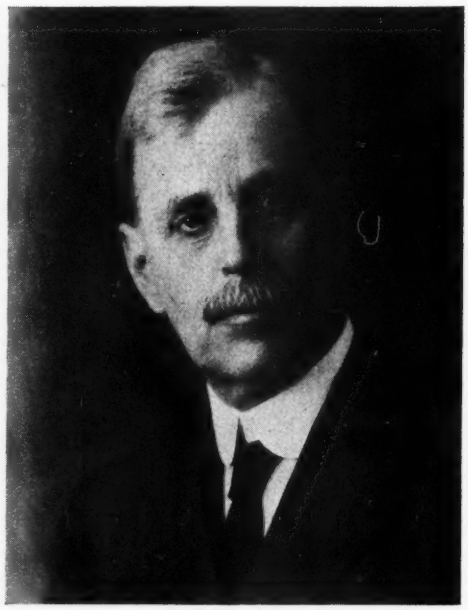
What then can we do to meet the intern shortage in a large number of our hospitals, particularly the medium-sized, non-teaching hospitals away from teaching centres? If we cannot get interns and if we must have resident help to carry out the many procedures linked with modern medicine, we must train nurses to perform many of the tasks now assigned to interns. I do not mean any pupil nurse but a graduate who is selected for that work, becomes proficient at it, and has a permanent place on the nursing staff. Such a person can write histories up to, but not including, the physical examination. She could take the blood pressure, take blood for Wassermans or for blood grouping, record the progress notes and be second assistant in the operating room.

—Harvey Agnew, M.D.

* * *

Association of Medical Record Librarians of Ontario

Among the interesting papers presented at the Annual Meeting of the Medical Record Librarians of Ontario, held in conjunction with the Ontario Hospital Association Meeting, was that of Dr. R. F. Farquharson, of the staff of the Toronto General Hospital, who spoke on "Medical Records from the Viewpoint of the Physician", "The Present Day Conception of the Value of Medical Records" by Dr. M. T. MacEachern, of Chicago; "Medical Records and the Social Service Department" as outlined by Miss J. M. Kniseley, director of the Social Service Department of the Toronto General Hospital; "The Value of the Medical Record to the Intern" by Dr. W. R. Feasby, resident physician, Toronto Western Hospital, and "Efficient Work in the Record Department", by Sister Mary Paul of St. Michael's Hospital, Toronto. On the final day a tour of the record departments in three large Toronto hospitals was arranged, bringing to a close another successful annual meeting of this association.



DAVID WILLIAMS, Esq.,
President, Ontario Hospital Association.

* * *

General Observations

A warm invitation to attend and participate in the great meetings of the International and American Hospital Associations, which are to be held in Toronto in 1939, was extended to all Ontario Hospital Association delegates by Dr. Malcolm MacEachern and Dr. Harvey Agnew, the presidents of those associations.

* * *

The Womens' Hospital Aids of Ontario are very proud, and justly so, of their institutional membership in the American Hospital Association. The illuminated and framed certificate of membership—the first to be given to any such group by the American Hospital Association was conferred "in consideration of the high standards of hospital service maintained, in recognition of its excellence as an institution giving scientific care to the sick and in appreciation of its value to its community".

* * *

"Strong family feeling" in his organization was the disarming explanation given by Dr. Malcolm MacEachern in his own defence, when Dr. Agnew, who introduced him for a luncheon address, in a recital of what he calls the "lipstick comedy" told of the impromptu and enthusiastic public farewell recently given Dr. MacEachern by three or four charming young members of his staff at the Grand Central Station in New York following the A.C.S. meeting. Dr. MacEachern is a strong believer in co-operation. We quote from a paper of his: "If a feeling of good fellowship prevails, the entire personnel will work together and will do more than their share when the occasional emergency arises". We wonder if this incident could be classed as an emergency.

Mental Hospitals to Join Association

At the meeting of the Manitoba Hospital Association it was stated that the Department of Health and Public Welfare has expressed approval of the provincial mental hospitals participating in membership of the association.

News of Hospitals and Staffs

Grey Nuns Mark Two Hundred Years of Service

The Sisters of Charity of the General Hospital of Montreal on October the 31st celebrated the 200th anniversary of the founding of their order. It was in 1738 that Mother d'Youville, a native-born Canadian woman, with three of her Montreal women, dedicated their life to the service of the needy. At present the organization possesses 5,300 members and extends west to the Pacific, south into the United States and north to Aklavik, in the Arctic.

* * *

New Wing of Kootenay Lake Hospital at Nelson, B.C. Opened

The formal dedication of the new Kootenay Lake Hospital 16-bed wing took place on October the 12th.

Kingston General Hospital Receives Bequest from Former Student

Kingston General Hospital, Kingston, Ontario, will shortly receive a $30,000 bequest from the estate of the late Mrs. Minnie Johnston of New York, who graduated from the hospital forty-nine years ago. Mrs. Johnston made the hospital her chief benefactor after a visit to the institution in 1931.

* * *

Hospital Grant Approved by Montreal Civic Authorities

The Montreal Council has accepted the recommendation that a $250,000 grant be made to Ste. Justine Hospital of that city, but will await a report from the Board of Health before final ratification.

(Continued on page 43)

Some Photographs at the Dallas Barbeque

Top left: Dr. George F. Stephens, Winnipeg, using his fingers; Leonard Shaw waiting for the core; President R. E. Neff awaiting his share; Bryce Twitty, Dallas, our genial host, and Dr. Bert Caldwell admiring the gallery.

Top Right: Four conspirators planning the Toronto convention. Dr. William S. Caldwell, Toronto, Chairman, Toronto Committee, holding the good luck school bell presented by Dallas, Texas; Dr. Bert W. Caldwell, A.H.A. Secretary; Leonard Shaw, A.H.A. Assistant Secretary; Carl I. Flath, Secretary Toronto Committee.

Bottom: Three of the Toronto delegates were so hungry they could not wait to be served. Note the fourteen steers a'sizzlin'.

Charlottetown Hospital Shortens Nurses' Hours

The eight hour duty schedule recently went into effect for student nurses at Charlottetown Hospital, P.E.I., and has so far proven very satisfactory.

* * *

New Hospital Opened at Fairview, Alberta

Dr. M. R. Bow, deputy minister of health for Alberta, was a guest at the official opening of the new hospital at Fairview on October the 11th.

* * *

Appointments and Resignations

Miss Norma Cox, superintendent of the High River Municipal Hospital, Alberta, for the past five years, has resigned.

Miss Jennie Sullivan, former superintendent at Harbor View Hospital, Sydney Mines, N.S., is the new superintendent at The Soldiers' Memorial Hospital, Campbellton, N.B.

Miss C. Fettes, who has been at the Durham Hospital for sixteen years, has resigned as matron of that hospital.

* * *

Book Review

TRIUMPH OVER PAIN. By René Fülop-Miller. Translated by Eden and Cedar Paul. 438 pp. $3.75. The Bobbs-Merrill Company, Indianapolis and New York. McClelland and Stewart, Limited, Toronto. 1938.

In the 19th century archaelogists came across a tablet from Nippur, recording in cuneiform writing the anguished prayer of a king's daughter, who, thousands of years ago cried, "Pain has seized my body. May God tear this pain out". This is the first written record we possess of man's pain, but myths and skeletal remains testify only too vividly that man's battle with pain began with life.

It was in 1846, less than a hundred years ago, that the first public painless operation under ether was performed, with Morton, "the little Boston dentist", administering his precious ether before a jeering and suspicious audience. That moment was the turning point in the long struggle against pain. For centuries pain had been considered eternal and ubiquitous and all man's cunning could not outwit the demon. Modern and ancient primitive peoples employed pitifully inadequate charms and ceremonies to guard against and placate the demon of pain, the Stoics advanced the "rational repudiation of pain", the schoolmen reduced it by "contemplation of divine things"; each philosophy and religion had its own interpretation of pain and its own way of sublimation, but none could conquer it. Indeed René Füllop-Miller says: "The most sublime forces of the human mind, religion, philosophy, sympathy, are to blame for the long continuance of our failure to understand the nature of pain". The religious and philosophical acceptance of pain as a moralizing agent and the failure to discriminate between physical and mental pain was long an effective barrier in the way of scientific explanation.

Surgery had been performed since the time of the cavemen, but the cure in this case was almost worse than the disease. Victims always prepared themselves spiritually for death before going under the knife, and the suffering caused was inhuman.

To trace the story of anaesthesia one must go back to

the thirteenth century when Raymond Lully called a white fluid that he had discovered "sweet vitriol". Two centuries later, Paracelsus, the "migratory physician", noted the pain-allaying properties of sweet vitriol—the same sweet vitriol of Lully's which, in 1792, was to be christened *ether* by the German apothecary Frobenius. Man was to hold the magic in his hands many times before putting it to use. Between 1792 and Morton's painless operation in 1846, the chemists made their contributions. Priestley, the chemically minded preacher, discovered nitrous oxide and Humphrey Davy experimented on his friends, Coleridge, Southey and Wedgewood, with the "laughing gas". Coleridge wrote of his first inhalation that he experienced "the most voluptuous sensations and entrancing visions", but popular opinion was against medical use of the gas and Davy turned to physico-chemical research. Faraday later found that ether had the power to produce complete unconsciousness for several hours, but his casual allusion to this in a scientific journal was ignored by official medicine.

Morphine was discovered in Germany and the formula for chloroform perfected in 1834 by a Frenchman. But the credulity of those who for so long had eagerly accepted the charms of the faith healers, the "healing touch" of saints and kings, was now replaced by a horror and distrust of the pain-killing drugs and gases. Official medicine and popular opinion appeared to be insurmountable barriers when, now and then, a lone disciple tried to fight pain with these weapons.

Finally, in 1846, Morton, the Boston dentist, offered indisputable proof of the anaesthetic powers of ether, and in five years surgery had been revolutionized. For Morton, the discovery of anaesthesia was the end of personal happiness. The rest of his life was a long and bitter battle against Jackson, his former teacher, for priority as discoverer of the anaesthetic powers of ether, and the end was tragic for both. The men who were the chief actors in the final drama of anaesthesia paid dearly for their roles.

Anaesthesia, however, was established and accepted. Only a year later, in 1847, Sir James Y. Simpson, a Scottish physician, used chloroform to allay the pangs of child-birth and the patronage of Victoria, Queen of England, effectively silenced the horrified protest of devout Calvanists. Since that time new drugs have been discovered, new methods of administration used—and new dangers realized. Once again the old problem of euthanasia has been brought into the limelight as a final triumph over pain. That final triumph remains a problem for the future.

Construction

The Claresholm Municipal Hospital Committee, Claresholm, Alberta, is going ahead with plans for the immediate construction of a new hospital.

* * *

The MacDonald Construction Company, Halifax, has been awarded general contract for construction of the T. B. unit at St. Joseph's Hospital. The same company is now working on the construction of an addition to the hospital proper.

* * *

Albert S. Macduff, Val d'Or, Quebec, is the architect for the proposed addition to the Ste. Therese d'Amos Hospital. Owners are the Grey Nuns of Nicolet at Ste. Therese Hospital, Amos.

* * *

Fredericton City Council has agreed to guarantee the $200,000 federal loan, which is to be used for construction of a new wing for the Victoria Public Hospital, by an issue of debentures to that amount.

* * *

Sketch plans of a new wing to the Chilliwack General Hospital at Chilliwack, B.C., by Gardiner & Mercer, Vancouver, architects, have been approved in main by provincial authorities. It is not likely, however, that construction on the proposed $100,000.00 wing will start till next spring.

Convalescent Care Passes Another Milestone in Montreal

(Continued from page 18)

continuous change of air throughout the building at all times. Every ward, locker room lavatory, service room, etc., is connected with the duct system. Additional forced ventilation is provided for the enlarged kitchen and the air is circulated through ducts up to the fan room and thence discharged at the roof of the building.

Care has been exercised throughout in the choice of materials for economy and due regard has been paid to a minimum amount of maintenance and up-keep.

The floors for the wards generally are of linoleum on cement finish with terrazzo, ceramic tile and asphalt tile at various locations. All the exterior terraces have quarry tile roofs, forming a good surface for the wheeling of beds, chairs, etc.

Acoustic plaster is used on all corridor ceilings to reduce the noise in the public areas. Acoustic material is also used in all kitchens, service pantries, etc. Walls, partitions and ceilings in other areas are generally plastered with a hard plaster, finished with a paint or tint.

Electric lighting is by means of standard lighting units and night lights at low levels are provided for all large wards. A nurses' call system was installed for all patients and telephones and radios are provided at selected locations. Passenger and service elevators travel from the basement to the top floor. All elevator and ventilating machinery is enclosed in a penthouse at the roof, separated from the main building by fireproof doors.

The building, of reinforced concrete structure with concrete floors on which the various finishes are directly set, is of fireproof construction throughout. Fire protection is

maintained by stand pipes and hose on every floor, with enclosed fire stairs and doors at suitable locations.

The architect for the original building was the late John S. Archibald, while the extension was designed and supervised by Archibald and Illsley, and Grattan D. Thompson, Associate Architects.
The heating, ventilating, lighting and sanitary engineering was designed by Walter J. Armstrong, M.E.I.C.
The building was constructed by Bremner, Norris & Co. Limited, Contractors and Engineers, Montreal.

Which is the Anaesthetic of Choice?

(Continued from page 20)

thesia there is less vomiting than after ether, but, strange as it may seem, there appears to be as much pneumonia following spinal as after ether. Severe headache is a rather serious complication which we have had after spinal. One patient had a very distressing headache for almost 6 months.

Value: Ether 50; Spinal 60; Cyclopropane 95.

7. Simplicity of Administration

Obviously ether is much simpler to administer than cyclopropane or spinal. On the other hand it does not require much training to be able to give cyclopropane, especially if one is accustomed to giving nitrous oxide or ethylene.

The technique of spinal anaesthesia appears simple but it is not always as easy as it looks. We have had four cases in which we failed to get the needle into the spinal canal, and had to revert to ether.

Value: Ether 100; Spinal 90; Cyclopropane 95.

8. Scope of Usefulness

Ether has been used in every conceivable type of operation, although it cannot be employed in operations about the head and neck when cauterization is required. We have never attempted to use spinal anaesthesia for any operation above the level of the diaphragm. Cyclopropane can be used for any operation where ether can be used and has the same limitations on account of its explosiveness. Incidentally, we do not take any extra precautions in our hospital on account of the explosive nature of Cyclopropane. Our operating room is partially air-conditioned and we can change the air in it every 10 or 15 minutes if necessary.

Value: Ether 90; Spinal 50; Cyclopropane 90.

9. Popularity

One of the best gauges of the value of an anaesthetic is the way in which it is received by surgeons and anaesthetists. From the reports received from various hospitals it would appear that cyclopropane has gained rapidly in favour.

Value: Ether 50; Spinal 50; Cyclopropane 100.

10. Cost

This, of course, has nothing to do with the efficiency value of the anaesthetic but from the Trustees' standpoint it is a rather important factor. In our hospital the cost per patient for ether was 55 cents, spinal varies from 40 to 75 cents, while the cost per patient of cyclopropane was $1,00, not including the oxygen.

Value: Ether 100; Spinal 100; Cyclopropane 50.

The Grand Total

What is the result of our analysis of the merits of each?

	Ether	*Spinal*	*Cyclopropane*
1. Safety	90	80	95
2. Potency	90	100	50
3. Control	90	50	100
4. Toxicity	90	90	100
5. Comfort	50	75	100
6. Complications	50	75	90
7. Simplicity of Administration	100	90	95
8. Scope of Usefulness	90	50	90
9. Popularity	50	50	100
10. Cost	100	100	50
	800	760	870

Each has its good points while none can be regarded as the ideal anaesthetic in all respects. Cyclopropane heads the list and deservedly so. The hospital that has not provided its anaesthetist with the facilities to administer cyclopropane is not giving its patients all the benefits of the advances made in anaesthesia in the past five years.

A Personal Preference

In conclusion, let me express my personal preference. If I should be so unfortunate as to require an abdominal operation at any time I would wish to be given a spinal anaesthetic, for I feel that the surgeon would then be working under the most ideal conditions; this would far outweigh any risks occasioned by this method of anaesthesia. However, I would make the proviso that if I should become "seasick" during the operation, when the surgeon begins to explore—and how they do love to explore!—I would want a little cyclopropane to ease the discomfort. If I should ever require a rib resection or a thoracoplasty I certainly would demand cyclopropane. If a thyroidectomy be indicated, I would like the surgeon to commence under local anaesthesia and, if things became disagreeably painful when working in the deeper structures, I would want some cyclopropane added. If I should ever require to have my tonsils removed, I would wish to have cyclopropane by the intratracheal method.

Accounting for Stores Control

(Continued from page 23)

minimum at the right proportions. It may be necessary to change this sometime. If any change is made, all sections of the hospital affected by change should be sent a typed memorandum.

After all requisitions have been posted for the day, and stores ledgerkeeper has noted on a purchase requisition the number of items that require ordering, the purchase requisition should be signed by accountant. The original of purchase requisition with a sample of goods to be ordered (if necessary) should be sent to purchasing clerk, and the duplicate and triplicate copies should be sent to storeskeeper. The storeskeeper should enter on duplicate

copy the amount of goods he has on hand at end of day and return same to stores ledgerkeeper. This gives the stores ledgerkeeper another chance to check goods in stock with ledger, and if they do not agree a check can be made at once. The triplicate copy of the order stays on file in storesroom to check with goods when received.

Inventory of Stores Stock

As stated previously we have two checks regarding the stock on hand. The first when ordering new stock, second when goods are received into stores. These check up some items more frequently than others. Some items are issued from stores sooner than others, but all items should be checked over regularly. Each morning the stores ledgerkeeper should give to the storeskeeper a dozen or so stores numbers to count at the end of each day when all stores requisitions are filled. This system would cover the entire storesroom stock several times a year. At the end of the fiscal period, the accountant should take a complete inventory of the stores. The inventory should be checked with ledger. All items that are in balance should be initialed and dated, and any items that are not should be adjusted only after they can not be located by checking over stores requisitions.

When is it a Disgrace to Balance the Budget?

(Continued from page 27)

absolutely necessary to balance the budget. Unmet deficits cannot continue to pile up year after year. The only alternative may be to close up shop. But, frequently a debit balance at the end of the year may be looked upon with pride. By incurring that deficit the hospital may have given that community a service far beyond the actual cost in dollars and cents, a service which, but for the hospital, could not have been given to the sick and needy of tha. community. A deficit may mean all the difference between a mediocre and incomplete effort to serve the sick, barely sufficient for the routine wants of a limited group of patients and a highly efficient up-to-the-minute service by a skilled group with sufficient equipment and facilities to cope with almost any situation. Other hospitals with higher per diem costs and with deficits may not be unbusinesslike or badly managed; on the contrary, they may be giving their community far better service than we are giving ours.

If to balance the budget, much needed service to the sick must be left undone, or be poorly done, if the real opportunities for service must be passed by, if inefficient, inadequate and slipshod service must result, then altogether too high a price has been paid for the satisfaction of "breaking even". It is then that it becomes a disgrace to balance the budget.

A reasonable deficit, incurred despite the utmost economy in non-essentials, is no disgrace. It may prove to be a blessing in disguise. It may be the means of proving to the townspeople that good service costs money, that their efforts hitherto have not been quite sufficient and tha. everyone will have to work a little harder than before. The most vital and inspired church congregations are those still with a mortgage hanging over their property. The hospitals are no exception to this rule.

Index of Advertisers

OPERATING ROOM NURSE DESIRES POSITION

WANTED: Position as Operating Room Nurse. Seven years' experience. Supervising three years. Post-graduate at Vancouver General. Apply to St. Michael's Hospital, Lethbridge, Alberta.

WANTED

At once Instructress for Training School, connected with the Soldiers' Memorial Hospital at Campbellton, N.B. Apply stating salary and experience to Eugene Savage, Chairman Board of Trustees, Soldiers' Memorial Hospital, Campbellton, N.B.